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ABSTRACT

This monograph outlines early prevention efforts that can decrease the development of destructive behaviors in at-risk youth. The text provides those who work with young people the information they need to identify individuals with the highest potential for "at-riskness." Such care givers also need to understand the causal factors for at-risk behavior. Many of the chapters include case studies that explore prevention efforts from individual, family, school, and community perspectives. It is believed that persons working with youth must understand how to use prevention strategies in dealing with those who are most at risk. The book is divided into three parts. Part 1 gives information on population definition, identification, and behaviors and causal factors descriptive of youth at risk. Part 2 deals with parameters that often serve as casual factors for the development of at-risk behaviors, and includes chapters on the effects of a dysfunctional family, physical and sexual abuse, and other conditions. In Part 3, the behaviors most often identified as placing youth at risk are explored, along with discussions of eating disorders, pregnancy, AIDS, gang membership, substance abuse, homelessness, and understanding and preventing school drop out. Individual chapters contain references. (RJM)

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# YOUTH AT RISK

## *A Prevention Resource for Counselors, Teachers, and Parents*

Edited by

**David Capuzzi**
and
**Douglas R. Gross**

**YOUTH AT RISK**
**Second Edition**

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# DEDICATION

*To: Kevin and Keith Capuzzi*

*Your supportiveness and quick wit made this book possible. You are wonderful role models, each in your own way, for other young people.*

*To: Lola Gross*

*With love all is possible.*

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# Preface

*Youth At Risk: A Prevention Resource for Counselors, Teachers, and Parents* is a revision of the original 1989 text. In this second edition, emphasis is placed on prevention efforts with at-risk populations. Many of the chapters include case studies that explore prevention efforts from individual, family, school, and community perspectives. Every effort is made to address the complexities of working with vulnerable youth in a way that provides professionals, as well as parents, with an information base as well as practical guidelines for successful intervention. This book differs from similar texts because of the attention placed on counseling and systems applications with youth at risk.

The text is based on the assumption that individuals working with young people need to have information that helps them identify the individual(s) with the highest potential for "at-riskness" within the population, and to understand the causal factors for at-riskness, and recognize the behaviors that place the individual(s) at the most risk. The text is also based on the assumption that persons working with youth need to understand the effective use of prevention strategies to deal with the individual(s) with high potential for at-riskness. Resources are given that provide current information related to existing prevention programs that have proven to be effective in working with the individual(s) with high at-risk potential within the population.

To meet these assumptions, the text, which is developmental in orientation, is divided into three parts. Part One presents information dealing with population definition, identification, and behaviors and causal factors descriptive of youth at risk. Information is also provided that serves as a foundation for understanding the parameters of the prevention-intervention paradigm.

Part Two of the text deals with parameters that often serve as causal factors for the development of at-risk behaviors. Included are chapters dealing with the effects of a dysfunctional family, physical and sexual abuse, low self-esteem, depression, and stress. Each chapter in Part Two not only identifies various aspects of the causal factor but also presents information related to prevention strategies designed to deal with these factors.

Part Three of the text deals with behaviors most often identified as placing youth at risk. These behaviors include those that lead to eating disorders, pregnancy, AIDS, suicide, gang membership, substance abuse, school dropout, and homelessness. Each chapter in Part Three provides information related to the specific behaviors, includes a case study to illustrate the information presented, and provides approaches to prevention from individual, family, school, and community perspectives.

Every effort has been made by the editors and contributors to provide the reader with current and relevant information in each of the 15 areas of focus. We hope that *Youth At Risk: A Prevention Resource for Counselors, Teachers, and Parents* proves to be an invaluable resource for individuals committed to assisting young people in the often difficult transition between adolescence and adulthood.

# ACKNOWLEDGMENTS

We want to thank the 24 authors who contributed their expertise, knowledge, and experience in the development of this text. We also want to thank our families who provided the freedom and encouragement to make this endeavor possible. Our thanks are also directed to ACA staff for their encouragement and assistance with copy editing and ultimately the production of the book. Thanks also to Joan Rabottini, graduate assistant for this project and a student in the community counseling specialization of the Counselor Education Program at Portland State University, who eased the burden of this task. Our thanks are also directed to the counselor educators at Portland State and Arizona State universities for their understanding and support.

Special acknowledgment must be given to Dr. Michael Reardon, provost at Portland State University. Funding of the graduate assistantship made it possible to employ Joan Rabottini, an excellent scholar and competent research assistant.

# ABOUT THE AUTHORS

**David Capuzzi,** PhD, NCC, LPC, is a past president of the American Counseling Association (formerly the American Association for Counseling and Development) and professor of counselor education at the School of Education at Portland State University in Portland, Oregon.

From 1980 to 1984, Dr. Capuzzi was editor of *The School Counselor.* He has authored a number of textbook chapters and monographs on the topic of preventing adolescent suicide and is coeditor and author, with Dr. Larry Golden, of *Helping Families Help Children: Family Interventions With School-Related Problems* (1986) and *Preventing Adolescent Suicide* (1988). He coauthored and edited with Douglas R. Gross the first edition of *Youth at Risk: A Resource for Counselors, Teachers, and Parents* (1989); *Introduction to Counseling: Perspectives for the 1990s* (1991); *Introduction to Group Counseling* (1992); and *Counseling and Psychotherapy: Theories and Interventions* (1995). He has authored or coauthored articles in a number of ACA and related journals.

A frequent speaker and keynoter at professional conferences and institutes, Dr. Capuzzi has also consulted with a variety of school districts and community agencies interested in initiating counseling and intervention strategies for adolescents at risk for suicide. He has facilitated the development of suicide prevention, crisis management, and postvention programs in communities in 25 states.

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Dr. Gross has contributed chapters to five texts: *Counseling and Psychotherapy: Theories and Interventions* (1995); *Youth at Risk: A Resource for Counselors, Teachers, and Parents* (1989); *Foundations of Mental Health Counseling* (1986); *Coun-*

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# I

# INTRODUCING THE PROBLEM

All persons, who either work with or live with youth, have become increasingly aware of the potential that exists for the development of at-risk behaviors. This awareness is enhanced by media coverage, educational reform, mental health programming, governmental mandates, and law enforcement reporting. This ongoing emphasis on the vulnerability of youth provides a call to action for all persons involved with this population. Prior to taking such action, however, it is important to understand not only the demographics of this population but also current definitions, at-risk behaviors, generic causal factors, and preventive and interventive approaches to dealing with youth at risk. Part One of this text provides this information. Chapter 1, Defining Youth at Risk, introduces the topic of "at-riskness" by providing the reader with foundational information related to definition, at-risk behaviors, and causal factors that enhance the development of at-risk behaviors. The chapter concludes with an introduction to the two approaches that are used to work with this population, namely prevention and intervention.

Building on this foundation, chapter 2, Prevention: An Overview, lays the groundwork for understanding the various strategies incorporated in the term *prevention*. In meeting this goal, information presented includes goals and purposes of prevention; primary, secondary, and tertiary concepts related to prevention; and program examples to illustrate prevention's place in the broad spectrum of helping. The chapter concludes with a comparison of prevention and intervention strategies.

These first two chapters provide a necessary foundation for all persons wishing to reduce the vulnerability of youth for the future development of at-risk behaviors.

# 1 Defining Youth at Risk

### *Douglas R. Gross and David Capuzzi*

As John Patton sat down at the large table in the conference room, he hoped that something positive could come from this meeting, perhaps something finally could be done to help some of the students in his classroom. He knew that he had been instrumental in forcing Ms. Callis, his principal, to call this meeting. He hoped that all of his colleagues attending shared his view on the urgency for taking some positive action.

This was John's third year of teaching, and each day he was confronted with problems in his classroom. The problems were not those of math, his subject area, but problems that he observed and that were reported to him by many of his students. The problems covered a wide range of areas including pregnancy, depression, drugs and alcohol, eating disorders, and dysfunctional families. Certainly, he was not the first to notice these problems, or the only teacher in whom students confided. If these problems were so obvious to him, why hadn't something been done to deal with them? Most of his students were now juniors in high school, and he was sure that the problems did not have their origins in attaining junior status.

He did the best he could, but he was not trained to handle these issues. In seeking direction, he talked with the school counselor, the school psychologist, and Ms. Callis. Although all of the persons contacted wanted to help, they were also overwhelmed by the demands upon their time. His questions for the most part went unanswered. If he was correct that these problems did not begin during the junior year in high school, why hadn't something been done earlier? Hadn't former school personnel recognized the difficulties these students were having? Hadn't parents asked for help with their children? Why hadn't something been done to prevent these problems from developing? John hoped that maybe answers would be forthcoming at the meeting.

John sat in his classroom after the meeting and reflected on what had happened. He was very pleased that he was not alone in his concern about students and that his colleagues had raised many of the same questions that plagued him. He was also pleased that many of his colleagues saw a need for adding trained personnel to work with teachers, students, and parents in developing strategies to intervene in the disrupted lives of many of the students before it was too late. John felt that the most helpful outcome of the meeting was that of exploring the development of prevention strategies aimed at early identification of problem behaviors and establishing programs directed at impeding their development. This

> outcome generated much discussion centering around such questions as "What constitutes prevention?" "How does prevention differ from intervention?" "What have other schools tried and what has worked?" "Do we need to go beyond the school to build a prevention program?" "What part will the community and parents play in the prevention program?" and "Are there community resources we can use to aid us in better dealing with the problems currently present in the school?" John sensed that the questions came more easily than the answers. The two major directives that came from the meeting were the establishment of a committee to investigate what is currently being done by other schools to develop an approach to prevention and the development of a list of community mental health services that could be utilized by the school to supplement the work currently being done by the school staff. John had volunteered to serve as chairperson of the committee investigating current programs and to assist in gaining information about community mental health services. He looked forward to the next meeting that was scheduled in 2 weeks.

This hypothetical situation has been repeated over and over in school districts across this country as teachers, administrators, community leaders, and parents attempt to better understand what needs to be done to provide effective programs to help with the growing numbers of young people who are labeled *at risk* due to their involvement in certain destructive behaviors as well as to help prevent the development of these destructive behavioral patterns. The question these concerned citizens are striving to answer is "Do we continue to deal from a crisis-management perspective with the problem behaviors of youth, or do we take a preventive approach to attempt to stop these problem behaviors from developing?"

The answer to both parts of this complex question is "yes." With the growing numbers of young people entering our educational systems identified as at risk, it is not possible to say "no" to continuing our crisis-management strategies. Due to these increasing numbers, however, most educational systems are not equipped to address this problem from a purely crisis-management perspective. Therefore, steps must be taken to attempt to stop its development. Such steps are usually described in terms of prevention modalities aimed at providing programs that will both identify young people with the highest potential for developing at-risk behaviors and stop these destructive behaviors from developing. Thus we must continue to intervene at the points of crisis and at the same time set into place prevention programs that will eventually reduce the need for crisis intervention.

This chapter first provides a foundational perspective on at-risk youth by presenting the definition, identifying the population, and describing the population's behavioral and causal characteristics. The chapter then introduces the broad concept of prevention by discussing a prevention and crisis-management paradigm.

## A FOUNDATIONAL PERSPECTIVE

Many problems are encountered in attempting to understand the concepts and issues that surround the term *at-risk youth*. Such problems center upon definition, cause and effect, and calculating and determining the population as well as the development and implementation of both prevention and crisis-management programs that impact the various destructive behaviors that place youth at risk. According to Conrath (1988), "Principals and teachers have known at-risk youth for a long time. They have recently been discovered by policy makers and budget sculptors. . ." (p. 36). Simple answers and agreed-upon definitions do not currently exist. The best we have at this time are experimental programs, a host of opinions, definitions, and population descriptors, and a high motivation to find workable solutions. The concepts that surround the students at risk and the most effective ways to deal with this at-riskness are complex, filled with frustration for those who attempt to understand them, filled with despair for those who attempt to affect them, and often filled with tragedy for the individuals so labeled.

Overwhelming statistics place the concepts and issues surrounding at-risk youth high on the priority lists of educators, mental health workers, counselors, social workers, parents, and community leaders. According to researchers Donmoyer and Kos (1993), Dryfoos (1990), McWhirter, McWhirter, McWhirter, and Mcwhirter (1993), and Schorr (1988),

- 700,000 students drop out of high school each year;
- 500,000 teenagers give birth each year;
- 24,000,000 children live in poverty;
- 14,000,000 children are being raised by a single parent;
- 2,000,000 children suffer from some form of abuse each year;
- 3,000,000 students and teachers are victims of crime each year;
- 500,000 robberies, burglaries, assaults, and rapes are committed in schools each year; and
- 7,000 teenagers commit suicide each year.

It is important to keep in mind that each day steps are being taken to reduce these staggering numbers. Educational, psychological, sociological, governmental, and community-based entities are developing and applying prevention and crisis-management strategies directed toward a society at risk. This book has as its major purpose providing these entities with information and direction in meeting their difficult tasks.

### The Definition

Tracing the exact origins of the term *at risk* as it applies to education and youth is impossible, but during the past 17 years, the term has appeared frequently in educational literature, federal reports, and legislative mandates from individual states. In 1988, *Education Week* reported that three out of four states have either adopted or are preparing a definition of their populations determined to be at risk (Minga, 1988); and although current data are not available, it is assumed that all states have by now established legislative parameters for their at-risk populations. A review of the known definitions reveals not only a lack of clarity and consensus but also that the term is explained most often from an educational perspective and indicates individuals at risk of dropping out of the educational system. The characteristics of at-risk youth presented in these definitions include the well-known risk factors of tardiness, poor grades, low math and reading scores, and failing one or more grades (Kushman & Kinney, 1988; McWhirter et al., 1993; Slavin, Karweit, & Madden, 1989).

A more interesting listing of characteristics was adopted by the Montana State Board of Education in April 1988. This definition (reported by Minga, 1988) is as follows:

> ...at-risk youths are children who are not likely to finish high school or who are apt to graduate considerably below potential. At-risk factors include chemical dependency, teenage pregnancy, poverty, disaffection with school and society, high-mobility families, emotional and physical abuse, physical and emotional disabilities, and learning disabilities that do not qualify students for special education but nevertheless impede their progress. (p. 14)

This definition speaks directly to the confusion that surrounds the issue of being at risk and somewhat indirectly addresses concerns regarding cause versus effect. From this definition, it could be concluded that behaviors such as tardiness, truancy, and low grades are the effects of identified causal factors, for example, chemical dependency, teenage pregnancy, and poverty (Donmeyer & Kos, 1993; Richardson, Casanova, Placier, & Guilfoyle, 1989).

If programs dealing with at-risk youth first attempt to deal with factors such as tardiness, truancy, and low grades, they may be placing the proverbial cart before the horse. If the desired effects are to reduce tardiness and truancy and to improve grades, with the ultimate aim of reducing the dropout rate, perhaps more attention needs to be directed toward such identified causal issues as are listed by the Montana State Board of Education. Underlying much of the confusion surrounding at-risk youth is the amount of emphasis placed on either cause or effect (behavior) or both. Whichever position is selected often determines both definition and strategies to operate within that definition. For example, if we approach this area from an effect (behavior) point of view, then what we need to do is identify the behaviors that place the individual at risk and develop strategies to change these behaviors. Or if we approach this area from a causal perspective, then we must try to determine what caused the development of the effect (behavior) and attempt to develop strategies that eliminate the causal factors, thereby stopping the development of the effect (behavior). But if we approach from both cause and effect perspectives, then we must develop strategies both to identify and eliminate the causal factors and at the same time put into motion programs that will change the behavior.

This latter approach—from both cause and effect perspectives—forms the basis for our definition of at risk. In this book, the term *at risk* encompasses a set of causal/effect (behavioral) dynamics that have the potential to place the individual in danger of a negative future event. This definition not only considers the effect (behavior) that may lead to a negative future event but also attempts to trace the causal factors that led to the development of the effect (behavior). For example, with school-age persons, one of these negative future events may be that of dropping out of school. The causal/behavioral approach identifies not only the behaviors that lead to this event but also the myriad causal factors that aided in the development of this behavior. This definition speaks directly to the need for programs to change existing negative behaviors and for prevention programs to tackle the precipitating events that serve as causal factors in the development of the negative behavior. When viewed from this causal/behavioral perspective, the concept of being at risk broadens, and dropping out is only one of many possible outcomes. Other risks include, but are not limited to, graduating without an education, without goals and objectives, without direction for what comes next, without an understanding of potentials and possibilities, without appreciation for self, or without a knowledge of one's place in the larger society.

When viewed from this causal/behavioral perspective, the concept of being at risk takes on new dimensions and places the emphasis on individual and systemic dynamics that may or may not lead to a wide range of destructive outcomes. Such a viewpoint emphasizes the vulnerability of all youth to be at risk and provides a strong rationale for the development of prevention programs directed toward stemming the negative impact of certain individual and systemic dynamics. This viewpoint directs attention to a set of causal issues and resultant behaviors that often have proven to be significantly related to the development of many personal and educational dilemmas faced by today's youth. Any one of these dilemmas could result in personal and educational impairment. In combination, the results could be both personally and educationally fatal. This book uses the causal/behavioral definition of being at risk and presents both information and strategies to deal with at-riskness from a preventive perspective.

## The Population

One of the basic issues confronting those wishing to work in the area of at-risk youth centers on the identification of the population. Who are these persons identified as being at risk? Is it possible to identify young people who, by behavior or circumstance, are more at risk than others? Are not all young people, based upon behaviors, environment, and developmental patterns, at risk? Specific answers to these questions are not readily available. The research literature in this area is as yet replete with more opinion and supposition than fact. Interest in this population is recent. Population identification may be possible only after the fact, as exemplified by the studies that deal with placing the label of *at-risk youth* on those who drop out of school, abuse alcohol and/or drugs, become involved in gangs, and attempt and/or complete suicide. In such studies, the population is identified by the specific behaviors manifested. Such an approach to identification, although interesting, limits the identification process of at-riskness to those who currently manifest the specified behaviors.

Another factor that may hinder gaining a comprehensive perspective on the population of at-risk youth is the fact that the terms *at-risk youth* and *adolescence* are used somewhat interchangeably. It seems that to be at risk is to be between the ages of 13 and 18. Such parameters are understandable when we realize that most of the behaviors that are used to describe at-risk youth are those that coincide with the turbulent and exploratory developmental period called *adolescence*. Factors such as sexual experimentation, first-time drug and alcohol utilization, ego and self-concept development, and peer inclusion and/or exclusion are descriptive of both adolescence and of the population labeled *at-risk youth*. Such age-specific parameters, however, are limiting and often rule out a large segment of youth, namely, those younger than 13, who also need to be a focus in any discussion of at-risk youth. If we limit our identification process of at-risk youth to adolescence, we may also limit issues of cause and effect. From this perspective, both causal and behavioral dynamics are correlated with entrance into and exit from the developmental stage termed *adolescence*. Based upon the definition of at-risk youth stated earlier and knowledge of human development, we take a somewhat different viewpoint in identifying this population and view adolescence as simply the emerging period for behaviors that have been developing over a much longer period of time.

In keeping with the definition and viewpoint, the population identified as at risk includes all youth regardless of age. All young people have the potential for the development of at-risk behaviors. The key words in this statement are *potential for*. All young people may move in and out of at-riskness depending on personal, social, educational, and family dynamics. No one can be excluded.

By expanding the at-risk population to include all youth, the doors are open to begin work with this population at a much earlier age, to identify causal factors in the individual's environment that may either encourage or impede the later development of at-risk behaviors, and to develop prevention programs for all youth regardless of age or circumstance. If all youth have the potential for the development of at-risk behaviors, preventive steps can be taken to see that the young person does not reach his or her at-risk potential. If this population also includes those who have achieved their at-risk potential, then crisis management steps can be taken to reduce the level of at-riskness and return them to a level more descriptive of *potential for*.

## Behaviors and Causal Factors

Based on the assumption that all youth have the potential for at-riskness, how then are we able to identify both behaviors and the causal factors that make these behaviors reality? Is it possible to spell out a direct cause-effect relationship, or is this relationship much more indirect and circular in nature? The answers to these questions are at best speculative and perhaps best understood by looking at the developmental period that describes this population and then by identifying the behaviors and causal factors related to this population from school, mental health, and home perspectives.

The developmental period from childhood through adolescence is characterized by rapid physical change, striving for independence, exploration and implementation of new behaviors, strengthening peer relationships, sexual awakening and experimentation, and seeking clarity relating to self and one's place in the larger society. Pressures exerted by family, school, peers, and society to conform or not conform to established standards contribute to the highly charged environment in which this developmental process takes place and the degree of vulnerability that exists within it for the individual. Ingersol and Orr (1988), in an article about adolescents at risk, discussed G. Stanley Hall's 1904 view of adolescence as a phase of "storm and stress" and painted a graphic picture of this developmental process in which adolescence is simply the emerging period for behaviors that have been developing over a much longer period of time:

> Still, for those who deal with adolescents in a therapeutic context, there remains a subgroup that does experience storm and stress, whose transition to adulthood is marked by turmoil and trial. Further, only a recluse could be unaware of the statistics that show an upsurge in adolescent suicide, pregnancy, and venereal disease, as well as continued patterns of drug and alcohol use and abuse, school dropouts, and delinquency. For some young people, adolescence is an extended period of struggle; for others the transition is marked by alternating periods of struggle and quiescence. During periods of stress and turmoil, the latter group's ability to draw on effective adaptive coping behaviors is taxed. The resulting maladaptive behavior risks compromising physical, psychological, and social health. These young people are at risk. (p. 1)

Terms such as *tumult, trial, struggle, compromise*, and *stress* lend credence to the difficulty that surrounds this developmental period of youth. Research dealing with this developmental period includes but is not limited to such impacting factors as eating disorders (Brownwell & Rodin, 1994), homelessness (Rafferty

& Shinn, 1991), sexual behaviors (Melchert & Burnett, 1990), abuse (Goldman & Galgino, 1990), affective disorders (Kovacs, 1989), substance use and abuse (Newcomb & Bentler, 1989), pregnancy (Furstenburg, Brooks-Gunn, & Chase-Lansdale, 1989), and suicide and suicide ideation (Capuzzi & Gross, 1989). Each of these factors is descriptive of either behaviors or causal factors that can be identified from the perspective of the school, the mental health community, and the home. The behaviors and causal factors are separated for purposes of discussion only. Many items could appear in each perspective's listing.

### From a school perspective.

*At-risk behaviors.* From an educational perspective, there seems to be a good deal of consistency regarding the behaviors of youth who fall within the parameters of the at-risk population. According to Aksamit (1990), Cohen and de Bettencourt (1991), Fad (1980), Grossnickle (1986), and Hahn (1987), the following behaviors are red flags for those at risk:

- tardiness;
- absenteeism;
- poor grades;
- truancy;
- low math and reading scores;
- failing one or more grades;
- rebellious attitudes toward school authority;
- verbal and language deficiency;
- inability to tolerate structured activities; and
- dropping out of school.

*Causal factors.* Behaviors such as those just listed, viewed either individually or in combination, aid in the identification process. However, this type of identification focuses on existing behaviors that need crisis management strategies to attempt to change them. A different approach, and one we support, identifies the causal factors that lead to these behaviors and suggests prevention programs that may keep these behaviors from developing.

Ekstrom, Goertz, Pollack, and Rock (1986) attempted to address these causal issues in their analysis of data from the U.S. Department of Education's High School and Beyond national sample of 30,000 high school sophomores and seniors. The researchers looked at sophomores in 1980 and 1982 and concentrated on the differences between graduates and nongraduates. Their findings indicated that behavior problems and low grades were major determinants of dropping out. Other determinants included family circumstances with few educational supports and parents uninvolved in the ongoing process of their child's education. Further, dropouts tended to have close friends whose attitudes and behaviors also indicated alienation from school.

In a study of a comprehensive high school in upper Manhattan, Fine (1986) concluded that the structural characteristics that may lead to dropping out include a school that has a disproportionate share of low-achieving students and insufficient resources to provide for this population; overcrowded classrooms; teachers who are predominantly White, leading to poor communication with minority students and a lack of understanding; and teaching styles based more on control than conversation, authority than autonomy, and competition than collaboration.

Barber and McClellan (1987) and Paulu (1987) addressed the dropout problem from the students' perspective and reported that the reasons students gave for leaving school included personal reasons such as family problems, pregnancy, and academic problems. Other reasons that spoke directly to problems inherent in the educational structure included the absence of individual help, more challenging classes, smaller classes, more consistent discipline and more understanding, support, and help by teachers as well as the presence of boredom and communication problems with teachers, counselors, and administrators.

### *From a mental health perspective.*

*At-risk behaviors.* Today, more and more young people are seen by mental health agencies either in terms of clients who present for treatment or through the mental health agency's consulting relationships with schools. Regardless of the nature of the involvement, the following behaviors are most often presented:

- drug and alcohol use and abuse;
- eating disorders;
- gang membership;
- pregnancy;
- suicide or suicide ideation;
- depression;
- sexual abuse;
- violence;
- withdrawal and isolation;
- low self-esteem; and
- school-related problems.

*Causal factors.* Based upon the behaviors identified, it is easy to realize that no single causal factor provides the answer as to why such behaviors develop, that it may be better to answer in terms of combinations of causal factors leading to somewhat predictable behaviors. Often listed as causal factors for many of the behaviors just identified are dysfunctional family dynamics, peer group pressure for inclusion/exclusion, lack of positive adult models, an uninspired educational system, learning difficulties that go untreated, increased violence within the community, homelessness and economic hardship, single-parent households, living in a highly stressed society, and physical, sexual, or psychological abuse (Cuban, 1989; Dryfoos, 1990; McWhirter et al., 1993; Ponterotto, Pace, & Kava, 1989; Robertson & Mathews, 1989).

### *From the perspective of the home.*

*At-risk behaviors.* Parenting in today's society presents many challenges, not the least of which is attempting to understand children and the various factors that have an impact on them. Parents do not have the objective, somewhat clinical, viewpoint of at-risk behaviors as do either school personnel or members of the mental health profession. Because of their close relationship with their children, the following is descriptive of what they might list if asked to identify behaviors that place their children at risk:

- failing to obey rules or directives;
- avoiding taking part in family activities;
- spending a great deal of time alone in their room;
- being secretive about friends and activities;
- not communicating with parents or siblings;
- displaying values and attitudes different from family;
- resisting going to school or discussing school activities;
- arguing about everything; and
- staying away from home as much as possible.

*Causal factors.* As the family and its dynamics are generally viewed as one of the major contributors (causal factors) to at-risk behaviors, what does the family identify as causal factors and where do they look for explanations? Families must look inside the family structure as well as to entities outside the family to arrive at causal factors. These include the educational system, the peer group, the media, the economic conditions that necessitate both parents working, the lack of time for family interaction, the violence so common in both the community and the society at large, the absence of extended family, the availability of drugs and alcohol, and the lack of funds or governmental support for child care (Baumrind, 1990; Capuzzi & Cross, 1989; Nock & Kingston, 1991; McWhirter et al., 1993).

## Origins of Causal Factors

The three perspectives illustrate not only the differing behaviors identified but also the differing opinions as to the origins of the causal factors that aid in the development of these behaviors. Is one more accurate than the other two? Does one provide a better answer than the other two? Are all three perspectives accurate? The answer to all three of these questions could be "yes" depending on the setting, the perspective of the person in the setting, and the individual under evaluation. No one single factor can explain the development of at-riskness; only in combination are we able to understand the impact these factors have on the developmental process. For example, the young person growing up in a dysfunctional family often internalizes aspects of this dysfunction. Such internalization may stem from physical, sexual, or psychological abuse and result in low self-esteem, poor school performance, drug and alcohol use, or gang membership. The causal factors stem both from the degree of dysfunctionality within the family and how the young person reacts to this dysfunctionality. We know that not all young people who live in a dysfunctional family environment achieve at-risk status. We do know, however, that the potential for at-riskness in this type of environment is high.

This same situation exists when we move from the family environment to the school environment. The child who enters school for the first time may find this environment both frightening and difficult. So much depends upon what is done to recognize these reactions in the child and to develop programs to aid the child in making the transition from home to school. First impressions can have a far-reaching impact on this person's movement through the educational system—an impact that has the potential for such future behaviors as poor grades, lack of interest in learning, disruptive behaviors, and eventually dropping out of the educational system.

Aligned closely with the school environment is the developing pressure of the peer group. Part of the developmental process from childhood through adolescence is the growing importance of the peer group and the need to conform or to belong. The peer group impacts youth in areas such as self-identification, self-esteem and self-worth, interactive styles, attitudes, values, and beliefs. As youth develop, the peer group is like a magnet that continually pulls them away from family and often encourages behaviors that are decidedly different from those espoused by the family. Young people attempting to find their place in the world are faced with making choices, choices that for the most part place them at odds with one of two pulling forces: the family or the peer group. The ensuing stress demands the use of coping strategies and decision-making skills, both of which are often not part of the young person's behavioral repertoire. Unless something is done to relieve this pressure, the young person may develop a wide range of emotional reactions or behavioral dynamics in an attempt to relieve the stress, including depression, aggressiveness, use of alcohol and drugs, eating disorders, and suicide or suicide ideation. Any one of these classifies the young person as being at risk.

Society provides a further environment that has the potential for causing at-riskness in young people. One influencing element within today's society is conflicting standards for youth. On one hand, through legislative action persons under the age of 18 have few rights. Decisions regarding many aspects of their life are made by parents or other adults. The message is clear: You are too young to make these important decisions. On the other hand, the media, which permeate so much of society, provide and promote all types of models that encourage youth to be more adult in terms of behaviors, clothes, physical appearance, and relationships. The pull that the media hold for youth is like that of the peer group. The only difference is that the pull may be even stronger and again may encourage youth to move away from the demands of the family, culture, racial and/or ethnic orientations, and religious teachings.

A second influencing element on youth in today's society is best summed up in the term *violence*. It is difficult to read a paper or view a newscast without being confronted with stories detailing robbery, rape, assault, murder, drive-by shootings, and gang-related retaliations. Most of these involve young people, and many take place in environments generally thought of as safe, for example, elementary and high school playgrounds and campuses. Faced with vivid examples of such violent responses together with the death of friends or peers, youth experience a great deal of uncertainty about their future. Such uncertainty creates stress, frustration, and often an attitude of hopelessness and helplessness. Any one of these enhances the at-riskness potential of youth; in combination, they almost assure it.

Within these four environments—the family, the school, the peer group, and society—are most of the causal factors that lead to at-riskness in youth. However, the internal environment (what the individual brings to and takes from this environment) of the individual should also be presented in terms of its place in this causal paradigm. What part does the individual play in response to these various environments? Are youth simply the victims without recourse? Or do they play an active role in determining their own at-riskness? As already noted, not all young people respond to these environments in ways that place them at risk. The research on resiliency (Garmezy, 1983; Werner, 1984) has discussed such factors as approaching life's problems in an active way; constructively perceiving pain, frustration, and negative experiences; the ability to gain positive attention from others; faith in a view of life that is positive and meaningful; and competence in school, social, and cognitive areas. According to McWhirter et al. (1993), such factors serve as protective shields that allow youth to avoid, regulate, and cope with negative conditions within their many environments. There are no data to indicate what percentage of youth fit this profile. Based upon the staggering figures presented earlier, it seems that the percentage is small. This leads to the conclusion that the majority of youth are not equipped to deal positively with the numerous negative causal factors stemming from the various environments in which they operate. Therefore, their lack of the identified resiliency characteristics make them highly vulnerable. Their internal environment thus plays a major role in adding to their at-risk potential.

## PREVENTION AND CRISIS-MANAGEMENT PARADIGM

The description of at-risk youth in terms of both causal factors and behaviors provides a logical entry into a discussion of the prevention and crisis-management paradigm as this relates to developing programs that will assist in either preventing the development of the problem behaviors or treating the problem behaviors that have developed.

## Prevention

Two basic criteria underly the development of effective prevention programs for at-risk youth: the causal factors that lead to at-riskness can be enumerated, and the population of young people who are impacted by these factors can be identified. Causal factors are enumerated for a variety of identified problems in this chapter and the chapters that follow, and there seems to be a good deal of similarity across these factors. The population of young people impacted by these factors is also identified in this chapter: all young people have the potential for at-riskness. With these two basic criteria established, prevention programs can be developed to keep the identified population from achieving its at-risk potential.

Prevention programs can be and have been developed for a wide range of potential at-risk behaviors. The theory behind prevention is simply "stop certain behaviors from developing." Prevention programming for at-risk youth applies this theory but in a somewhat more comprehensive manner. Effective prevention programs directed at at-risk youth are generally viewed as multidisciplinary and are developed based upon the knowledge and expertise of several publics. For example, a prevention program directed at alcohol and drug abuse might involve not only school personnel (teachers, counselors, administrators) but also parents, students, community leaders, religious leaders, police, and representatives from various human service organizations. A multidiciplinary approach assures the widest range of expertise, involvement of those most likely to be affected by the program, and a commitment from the community in making the program work. It enhances the physical and financial resources of the proposed program and alerts young people to the fact that this is not just a school-based program but one that has the backing of both their parents and the community.

Because the program has prevention as its purpose, as opposed to crisis management, information will be provided regarding alcohol and drug use, redesigning environments to remove the availability of alcohol and drugs, changing existing policies and procedures within the educational system to enhance the prevention of alcohol and drug use, changing parenting styles and rules and regulations within the home to better accommodate the needs of the young person, designing alternative activities for young people that do not include alcohol and drug use, and providing peer mentoring systems to allow young people to learn from each other. These are just examples. One of the key factors in prevention program development is individualizing the programs to better meet the unique needs of the targeted population, the school, and the community.

According to Coyne (1994), many of the identified problems of at-risk youth are preventable. What is needed are well-designed programs that take into consideration such factors as knowledge and understanding of the concepts that define prevention, local assessments to define target population, information regarding existing programs both locally and nationally, and the selection of multiple strategies for implementation of the program. This is best done through a team composed of many individuals representing a broad spectrum of the community. This broadened base not only expands the knowledge and skill base of the program but also assures financial and personal commitment from the many publics impacted by the program, including students, parents, school personnel, and members of the community. Once the program is designed, it can be piloted and then restructured as needed. When the team is satisfied that the program is ready, formal implementation can take place. Evaluation is continual, and the program is revised as necessary. A more in-depth discussion of prevention is found in chapter 2, and each of the 13 chapters that follow present prevention programming with a problem-specific focus.

## Crisis Management

Although crisis management is not the main thrust of this book, it is important to understand the basic differences between prevention and crisis management. Whereas prevention programs have as one of their basic goals reducing the at-risk potential for youth, crisis-management programs have as one of their basic goals eliminating at-risk behaviors and providing new behaviors, coping skills, and knowledge that will keep the at-risk behaviors from reoccurring. In the first, we attempt to stop something before it begins (primary prevention), and in the second, we attempt to stop something from continuing (secondary and tertiary prevention). Underlying the development of either secondary or tertiary prevention programs are that many of the behaviors discussed in this chapter are currently present in a large percentage of youth and that steps need to be taken to change or remediate these behaviors. It is too late to prevent these behaviors from developing; they are present. Therefore, programs are designed to eliminate or reduce the behaviors that have placed the individual at risk. In so doing, programs, which may be aimed at either individuals or groups of individuals, identify the problematic behavior(s), identify the individual(s) operating within this behavioral pattern, design programs based upon current knowledge or select existing programs that have proven effective, implement strategies, and then evaluate the results of the implementation. Similarities between programmatic aspects of primary prevention and secondary and tertiary prevention are obvious. Differences also exist.

Secondary and tertiary prevention often occur in a structured setting such as a treatment center, mental health clinic, or school counseling office. In these settings, counseling/therapy is provided to address specific problem behaviors and varies according to identified problem behaviors, theoretical orientation of the counselor/therapist, institutional/organizational policies, parameters of insurance reimbursement, and the willingness of the individual to take part in the process.

Secondary and tertiary prevention are often of a more immediate nature than primary prevention due to the severity of the presenting at-risk behavior. Programs aimed at preventing youth from developing suicidal behaviors do not have the same immediacy as programs developed to deal with youth who have attempted suicide. Primary prevention programs tend to deal with healthy individuals or those with the potential for at-risk behaviors, whereas secondary and tertiary prevention programs tend to deal with individuals who have moved from healthy life-styles to unhealthy life-styles. A final difference is that primary prevention programs tend to be group or population based, and secondary and tertiary prevention programs focus more on the individual and his or her place in the larger group. Similarities and differences among these differing levels of prevention will become clearer in the chapters that follow.

## SUMMARY

This chapter provides a working definition of at-risk youth, information pertaining to both the causal factors and behaviors that are descriptive of this population, and general information related to the similarities and differences between prevention and crisis management. Such information could have helped our hypothetical teacher, John Patron. It could have provided some foundational material to aid him in better understanding the various parameters that surround the students in his classroom. It could have provided him with directives as he began to seek out information regarding what is currently being done to develop approaches to prevention and regarding community resources that could be utilized by the school. If John had the opportunity to read the following 14 chapters, he could be in a much better place in terms of answering the many questions raised at the meeting. For those who share some of John's concerns, have questions similar to John's, and feel the need to know more about the areas of at-risk youth and prevention, this book can be of great assistance. The true benefit of the knowledge gained will be not only better service for those youth who have a potential for developing at-risk behavior but also better preparation for dealing with those youth whose behaviors currently place them at risk.

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# 2

# Prevention: An Overview

*David Capuzzi and Douglas R. Gross*

The number of children and adolescents who engage in behaviors (e.g., unprotected sex, substance use and abuse, abnormal eating patterns) and are exposed to environmental factors (e.g., abuse, violence, homelessness) that place them at risk for adverse mental and physical health consequences is increasing at alarming rates (Kazdin, 1993). In addition, many children and adolescents are experiencing serious psychological and emotional impairment. Because the impairments that youth experience can persist and increase in severity across the life-span, the importance of early prevention and intervention efforts has increased in significance.

Robert Conyne (1994) emphasized the significance and importance of early prevention efforts by offering examples of some of the problems that characterize contemporary residents of the United States:

- There are 20 million illiterate adults. This amounts to 13% of the U.S. population.
- Nineteen percent of the population (or 43 million adults) have been identified as experiencing some type of mental disturbances.
- The number of youth dropping out of school each year has reached 1 million or 25% of those enrolled in K-12 settings.
- AIDS has become one of the leading causes of death among the 15- to 24-year age group.
- Nearly 5,000 infants are born each year with fetal alcohol syndrome.
- Adolescent suicide ranks second or third in most reports of the leading causes of death in the 11- to 24-year age group.
- First marriages end in divorce 50% of the time, and 50 to 75% of child mental health referrals are for children impacted by divorce.
- Almost 18.5 million Americans abuse alcohol, and over 100,000 alcohol-related deaths occur annually.
- Increasing numbers of women—3 to 4 million annually—are physically assaulted by intimate male partners.

The cost associated with these examples in terms of economics is staggering: approximately $273 billion was spent in 1990 in treatment and social services associated with alcohol, drug abuse, and mental illness (Horner & McElahaney, 1993). These costs do not include those associated with teenage pregnancy, AIDS, eating disorders, suicide, homelessness, and school dropout. When these additional areas are taken into consideration, the estimated figure increases to incomprehensible levels. As significant as these dollar amounts are, however, they do not include the immeasurable costs associated with human loss and suffering and the concomitant issues related to grief and loss.

In the wake of the need for counseling and therapy created by conditions in the North American culture, the availability of the supply of counselors, social workers, psychiatric nurses, psychologists, and psychiatrists pales by contrast (Conyne, 1994). Mandates connected with managed care and the understaffing of social service agencies further compounds the difficulties experienced by children, adolescents, and adults in need of assistance from the professionally prepared, licensed helper.

Prevention is based upon a different approach to help giving than that associated with prevalent diagnostic/prescriptive approaches. Prevention is not focused on dysfunction and associated remediation; it is focused on a proactive approach designed to empower the individual, change systemic variables, and forestall the development of dysfunction.

## DEFINING QUALITIES OF PREVENTION

As noted by Conyne (1994), Gilliland and James (1993), and Janosik (1984), prevention efforts focus on averting human dysfunction and promoting healthy functioning. The emphasis in prevention is on enhancing optimal functioning or well-being in psychological and social domains and on the development of competencies. This emphasis is in contrast to an emphasis on the identification and diagnosis of various disorders or maladaptive behavioral patterns in individuals and the provision of treatment to lessen impairment (Kazdin, 1993). Prevention efforts are characterized by a number of defining qualities:

1. *Prevention efforts are proactive.* Prevention initiatives address individual and systemic strengths and further develop those strengths so that dysfunction either does not develop or does not manifest itself to the point that impairment occurs. This contrasts with reactive approaches that are designed to intervene after problems have developed.
2. *Prevention efforts focus on functional people and those who are at risk.* As noted by Conyne (1994), prevention services (e.g., classroom guidance, individual or small group counseling) focus on those who are healthy and coping well so that strengths may be identified and enhanced and additional skills can be learned. Prevention efforts are also directed to those known to be at risk such as children of divorce, children of al-

coholics, or the homeless. The purpose is to provide proactive intervention so that future difficulties are avoided.

3. *Prevention efforts are cumulative and transferable.* When professionals help others through prevention, every effort is made to point out relationships and to assist clients to master a hierarchy of skills. For example, elementary aged children who have participated in groups designed to enhance self-esteem may, at a later date, feel good enough about themselves to participate in assertiveness training. Ability to use assertiveness skills may be useful in the context of refusing drugs; these same skills may prevent a youth from being victimized in some other situation.
4. *Prevention efforts are used to reduce incidence* (Conyne, 1994). Prevention activities are used before the fact so that problems do not develop. They might also be used to reduce the incidence of a new dysfunction.
5. *Prevention efforts promote peer helping.* When elementary, middle school, and high school youth learn to enhance communication, assertiveness, problem solving, and other related abilities, they are better able to help peers, encourage friends to seek professional assistance, and participate in supervised peer-helper programs. In many instances, the power of a member of the peer group outdistances that of a concerned adult in terms of providing encouragement, support, and straightforward feedback.
6. *Prevention efforts can be group based, population based, or individual based.* Many are focused upon at-risk populations (e.g., information and discussion about the HIV virus or hepatitis-B may be shared with sexually active adolescents, or victims of abuse may be assisted so that they do not develop lifelong dysfunctional patterns). Prevention may also be focused entirely on an individual so that suicidal preoccupation can be eliminated or depression can be overcome. When larger populations are reached through prevention programming, it is possible to impact the life space of large numbers of people (Conyne, 1994).
7. *Prevention efforts can be used early in the life-span.* We know that children who are homeless or who have been physically or sexually abused may develop traits and self-concepts that put them at risk during adolescence and adulthood. Early prevention efforts can effect changes in self-esteem, behavior, feelings, and thinking so that these children are not at risk of substance abuse, prostitution, depression, and suicide at a later time.
8. *Prevention efforts target more than a single system.* Because each person must simultaneously interact in a variety of environments, practitioners do not emphasize one system to the exclusion of others. Healthy individuals must learn to cope with the demands of several systems on a daily basis.
9. *Prevention efforts are sensitive to the needs of diverse populations.* No constellation of services or approach to prevention can make equal impact on all groups. Diverse populations present unique challenges; what one

population finds acceptable may be totally incompatible with the needs of another. Practitioners must be sensitive to the traditions, needs, and differences presented by subcultures in North America (Conyne, 1994).

10. *Prevention efforts are collaborative.* As noted by Conyne (1994), prevention efforts can be complex and must be conducted in concert with professionals from a number of disciplines. For example, a counselor working with a depressed adolescent may need the assistance of a psychiatrist or nurse practitioner if medication is needed along with counseling to control a body-chemistry-related bipolar pattern of depression. Often the expertise needed to assist an individual, a family, or a larger population may require input and teaming among professionals from several disciplines.
11. *Prevention efforts are applicable in more than one context.* Faculty and staff in a school setting, for example, may seek the assistance of someone who can provide staff development, train a crisis team, and provide input relative to a written crisis-management plan. Such efforts may be focused, initially, on substance use and abuse prevention or suicide prevention. After the adults connected with a particular school or school district have been prepared with respect to one particular at-risk population, they can usually apply the same principles and process to providing prevention services to another at-risk group.
12. *Prevention efforts are empowering* (Conyne, 1994). Empowerment should be the primary goal of all prevention efforts. This empowerment should apply not only to the recipients of prevention efforts but also to the providers of prevention services. When those receiving assistance build on strengths and learn new coping skills, they feel better about themselves and their ability to make responsible, healthy decisions. As professionals increase their ability to enrich the lives of others, they, too, feel productive, competent, and capable of impacting change.

## APPROACHES TO PREVENTION

A number of experts in contemporary prevention strategies (Hadge, 1992; Janosik, 1984; McWhirter, McWhirter, McWhirter, & McWhirter, 1993; Roberts, 1991) identify prevention as either primary, secondary, or tertiary prevention. As practitioners consider prevention strategies for possible implementation with an individual, a family, a school, or a community, it is important to be able to assess needs and identify strategies relative to whether these strategies can be categorized as primary, secondary, or tertiary.

### Primary Prevention

Primary prevention involves proactive planning of strategies and activities to keep specific problems or crises from developing in the first place (Gilliland &

James, 1993). In primary prevention, the purpose is to reduce the incidence of future problems by reinforcing internal coping ability, modifying external variables, or both. Primary prevention provides assistance prior to the development of problems through counseling, teaching, or other services that emphasize anticipatory planning. Through anticipatory planning, individuals of all ages are given the opportunity to select and practice behaviors that are helpful in both present and future circumstances.

Examples of primary prevention include parent education programs to prevent child neglect and abuse, and educational programs on university campuses to prevent sexual harassment, date rape, or violation of affirmative action guidelines. School programs for teenage men and women regarding the consequences of teenage pregnancies, the impact of school dropout, or the importance of effective communication skills are additional examples of primary prevention. Entire communities might also benefit from primary prevention efforts. For example, a series of mental health education seminars might be offered, free of charge, to residents of a community and might be collaboratively planned by representatives from the local schools, mental health services, and business sectors. Television and radio journalists might provide coverage of the services offered by women and children's shelters or local crisis hot lines. Whatever the emphasis, the focus is always upon preventing future and, more often than not, long-term pain or impairment.

## Secondary Prevention

Secondary prevention consists of early intervention with people in crisis for the purpose of restoring equilibrium as soon as possible and reducing the impact of the distress. During periods of crisis, people are aware that the situation is out of control; they may feel helpless. Unless secondary prevention is made available, a crisis may escalate to the point at which it may be difficult to contain or consequences may be irreversible. For example, a suicidal adolescent who does not obtain assistance may attempt suicide, survive, and be left with lifelong physical impairment and emotional turmoil that overlays the traits and characteristics that precipitated the suicidal crisis in the first place. When individuals, families, schools, or communities recognize the parameters connected with a crisis situation, they may be quite motivated and extremely receptive to secondary prevention efforts.

Examples of secondary prevention include support groups for students who are experiencing the grief and loss associated with the unexpected death of a peer, school and community collaborative efforts to provide child care and alternative education opportunities for teenage parents, residential or outpatient treatment for teenagers who abuse alcohol, or counseling services established to stop battering or other violent behavior. During the secondary prevention process, emphasis should be placed on individual, family, school, and community resources and abilities. Preoccupation with defeat and negative consequences seldom results in the management of a particular crisis situation and the reestablishment of equilibrium.

### Tertiary Prevention

Tertiary crisis prevention attempts to reduce the amount of residual impairment that follows the resolution of some crisis. Adolescents who complete residential or outpatient programs for substance abuse may benefit through participation in weekly support groups, facilitated by a professional, for the purpose of providing the reinforcement and support needed to prevent relapse. These same adolescents may need to participate, concurrently, in individual counseling or therapy to address the unmet needs that led to the use and abuse of a substance in the first place because emotional development and coping skills are usually arrested about the time substance use begins. Victims of sexual abuse may participate in either group or individual (or both) counseling or therapy long after the abuse has ceased for the purpose of repairing damaged self-esteem and rebuilding the capacity to trust and share intimacy with significant others.

As emphasized by Janosik (1984), crisis in contemporary society is so prevalent that it is not possible for all those experiencing crisis to access the help of professionals. It is possible, however, to identify factors that place individuals, families, schools, and communities at risk; thus it is of paramount importance to reduce emotional pain, residual impairment, and cost to the society as a whole through judicious use of prevention, whether primary, secondary, or tertiary in nature.

## TYPES OF PRIMARY PREVENTION

The youth of today are faced with coping amidst a society that is more populated, more connected by advanced communication technology, and more complex with respect to a variety of psychosocial stressors. This edition of *Youth at Risk* places more emphasis on prevention with respect to causative factors (such as low self-esteem, stress, depression) and a number of at-risk behaviors (such as drug abuse, unprotected sex, eating disorders, suicidal preoccupation, gang membership). The chapters that follow highlight secondary and tertiary prevention efforts. This chapter provides information on primary prevention efforts based on the types described by McWhirter et al. (1993): developing life skills, enhancing interpersonal communication, learning strategies for cognitive change, achieving self-management and self-control, and coping with stress.

### Developing Life Skills

*Life skills* can be defined as the ability to make use of personal resources for the purpose of expressing needs and positively influencing the environment. Such skills influence the formation of relationships and friendships, nonviolent methods of conflict resolution, and communicating with adults (McWhirter et al., 1993). Developing life skills can be accomplished through education and training in life skills, school peer mediation, peer tutoring, and peer facilitation.

Education and training in life skills involve developing and incorporating instructional modules into the curriculum at elementary, middle, and high school levels. Also involved is the collaborative input of a variety of professionals (counselors, nurses, physicians, social workers, psychologists, physical educators, classroom teachers) for the purpose of teaching skills needed by most individuals on a day-to-day basis. The format for teaching any targeted skills should, ideally, contain the following components: teach, model, role-play, provide feedback, and assign homework. Almost any skill can be taught within this paradigm, and the fact that implementation is most often effected in the classroom means that entire populations can be accessed so that more and more young people can master skills that can help them avoid future problems.

School peer mediation, peer tutoring, and peer facilitation all involve training and supervising students to perform interpersonal helping tasks. School peer mediation requires trained peer mediators who work in partnerships with other students for the purpose of facilitating problem solving between disputing students. As noted by McWhirter et al. (1993), peer mediation ensures that both peer mediators and peer disputants increase experience with critical thinking, problem solving, and self-discipline.

Peer tutors are students who teach other students in both formal and informal learning situations. Peer tutoring can provide a cost-effective means of meeting individual needs, developing better ownership of the value of the educational experience, and enhancing self-esteem and motivation.

Peer facilitation, sometimes called peer helping, is a process in which students are trained to listen, paraphrase, support, and provide feedback to other students in the school. Peer facilitation is an effective way to empower children and adolescents and to provide adjunct support to the professional counselor or other human service specialist.

## Enhancing Interpersonal Communication

Interpersonal communication skills are primary factors in the development of mutually beneficial relationships. Most programs designed to enhance interpersonal communication skills offer training in verbal and nonverbal communication, creation of constructive friendships, avoidance of misunderstanding, and the development of long-term relationships with significant others (McWhirter et al., 1993). Lack of ability to communicate well with others can lead to lowered self-esteem, isolation, and the development of future at-risk behaviors. Assertiveness training as well as resistance and refusal training are often important components of training in interpersonal communication.

Assertiveness training is most often accomplished in the context of small groups. It can include providing assistance with expressing positive and negative feelings; the ability to initiate, maintain, and end conversations; and practice on setting limits. Nonverbal communication is an important component of assertiveness training because the manner in which something is communicated—body language, eye contact, personal distancing, voice tone—can influence the message as much as the context of the message itself.

Resistance and refusal training is provided to help children and adolescents resist peer pressure or other negative social influence. Students are taught to label and recognize various forms of pressure and develop behavior to resist such pressure and influence. Both assertiveness training and resistance and refusal training provide numerous modeling, role-play, feedback, and reinforcement opportunities during the process of acquiring such interpersonal communication skills so that new behaviors are more likely to be used in day-to-day interactions with peers.

## Learning Strategies for Cognitive Change

Because cognition mediates both behavior and affect, cognitive restructuring can be an effective primary prevention strategy. Techniques used in problem solving and decision making, self-management and self-control, and cognitive restructuring are among the primary prevention strategies that can be taught to children and adolescents.

All young people have the potential to problem solve and make decisions. At times, however, the emotional components connected with a particular problem, the egocentric focus commonly associated with the early years of human growth and development, and the lack of experience with systematically approaching problem-solving situations provide barriers to effective problem solving and decision making (McWhirter et al., 1993). Instruction can be provided, however, in each step of the problem-solving and decision-making process. Teaching children and adolescents how to resolve problematic situations can help them enhance self-esteem, overcome feelings of being helpless, and promote a generalized sense of empowerment. McWhirter et al. (1993) suggested that the following components be taught:

1. *Define the problem.* The problem is defined as clearly as possible and is stated as a goal to be achieved. This goal is assessed: Does it meet the underlying needs? If it is attained, does it help the individual achieve satisfaction?
2. *Examine variables.* The specifics of the total situation are examined. Background issues and environmental factors are considered, so it may be necessary to gather and appraise additional information. It is particularly important to identify the feelings and thoughts of the youngster at this step. Often earlier maladaptive responses must be modified. In both this step and step 1, questions and suggestions from other students in the classroom or the group are useful.

3. *Consider alternatives.* Various means of solving the problem are considered. The strengths and weaknesses of each possibility are evaluated. Again, the teacher or counselor may call for brainstorming to generate ideas from other students about alternatives and strategies.
4. *Isolate a plan.* The alternatives are gradually narrowed down until what seems like the best response or solution remains. A plan for carrying out this alternative is prepared, and the potential consequences are considered in more detail.
5. *Do action steps.* After a plan is decided upon, action must be taken to implement it. Thus youngsters are systematically encouraged to follow through on the necessary steps to carry out their plan. They perform the behaviors that make up the solution plan.
6. *Evaluate effects.* Finally, youngsters need to evaluate the effectiveness of the solution. Teaching them to look for effects in their thoughts and feelings is important. They analyze and evaluate the outcome, review the decision, and, if necessary, develop another plan to achieve their goal. (pp. 276–277)

McWhirter et al. called their model the DECIDE model and reported that it is an effective strategy for teaching problem solving and decision making.

## Achieving Self-Management and Self-Control

Self-management means that self-control has been achieved. It implies that individuals can develop the ability to control, to a great extent, thoughts, feelings, and behaviors. Teaching children and adolescents the techniques of self-management and self-control can result in outcomes similar to those connected with teaching problem solving and decision making, enhanced self-esteem, overcoming feelings of being helpless, and a sense of empowerment. Teaching self-management and self-control involves teaching children and adolescents self-assessment, self-monitoring, and self-reinforcement (McWhirter et al., 1993). Self-assessment means that the individual learns to evaluate his or her own behaviors against a standard that has personal meaning in order to determine whether the behavior is adequate. Self-monitoring requires that the individual observes his or her own behavior and records it. Record keeping may involve notation of contingencies in the environment prior to and immediately following the behavior. Self-reinforcement involves supplying one's own consequences for a given behavior (e.g., self-praise, buying something of personal significance). Generally, children and adolescents who master the techniques of self-management and self-control feel energized, motivated, and positive about themselves.

## Coping With Stress

The term *coping with stress* is particularly significant in contemporary society. There are so many potential stressors encountered by each of us on a day-today basis that it behooves the adults in our society to teach children and adolescents as much as possible about stress and stress management. It is an important primary prevention strategy. Chapter 7, The Society We Live In: Stress and Coping, addresses this topic fully through discussion and analysis of perspectives on the stress concept, including stimulus-oriented views, response-oriented views, stress as a transaction between person and environment, life event stressors, daily stress, home and family stress, school stress, and developmental stress.

## PLANNING PREVENTION PROGRAMS

Laudatory prevention efforts of schools and communities have failed because planning efforts have not included important steps or a group of concerned adults has moved to the implementation stage and short-changed the entire planning process. The following steps, which are based on our experience in a variety of school and community settings, will help assure success.

1. *Read the research on prevention programs.* There are excellent reviews and monographs on approaches to prevention (Goldston, Yager, Heinicke, & Pynoos, 1990; Weisberg, Caplan, & Harwood, 1991). Often practitioners who are anxious to implement programs and services do not take the time to learn about and build upon the successes and failures of others. Based on numerous outcome studies, a number of generalizations can be made:

    - Prevention programs directed to the early years (e.g., pre- and postnatal parents and children during preschool years) can reduce factors that increase risk for maladaptive behaviors. Most of these efforts are focused on primary prevention and reduce the incidence of dysfunction in childhood and adolescence (Lally, Mangione, & Honig, 1988).
    - School-based programs targeting adolescents have improved prosocial competence and decreased at-risk behaviors (such as the behaviors discussed in Part Three) (Schinke, Botvin, & Orlandi, 1991; Schneider, Attili, Nadel, & Weissberg, 1989).
    - Broad-based programs aimed at several causative factors or at-risk behaviors seem to be the most successful because youth at risk usually present with a number of conditions (Caplan & Weissberg, 1989).
    - Occasionally programs have not been effective or have made problems escalate (Bangert-Drowns, 1988). Finding out why could be extremely important to practitioners prior to implementing any prevention effort.
2. *Assess needs.* Sometimes the professional helper fails to target the right population, the best combination of causative factors, or the at-risk be-

haviors of most concern to children, adolescents, and their families. It is important to touch base with the population being served prior to doing much planning. Children and adolescents, families, school faculty and staff, and components of the community (hospitals, businesses, churches, social service agencies) should be asked about their view of factors creating risk, problematic behaviors, and skill deficits. Prevention programming should always be designed to address needs and concerns identified by recipients of future services.

3. *Meet with administrators, elected officials, and business owners*. Prevention efforts take time, commitment, and money to implement. Numerous prevention programs have met with failure because planners failed to obtain the input and support of those in positions to reinforce efforts and keep programs and services funded and in place on a long-term basis. This is a critical step in planning for program support.
4. *Establish a broad-based planning group*. Educators, parents, youth, administrators, mental health professionals, physicians, nurses, and police should all be included in planning efforts for prevention programming. The more interdisciplinary and representative the group, the richer the input. The best prevention efforts have been based on the collaborative teaming of members of the community to be served.
5. *Target the population, the causative factors, or the at-risk behaviors*. Often planning groups are too ambitious with respect to goals and expectations. There is always more to be accomplished than can be realized with respect to a given prevention program. It is important to use the results of a needs assessment to target initial efforts so that initiatives are well planned and supported by adequate resources. Once a focus has been established, findings of research conducted relative to similar populations, risk factors, or at-risk groups should be utilized so that problems can be circumvented and past successful practices can be employed.
6. *Identify existing prevention programs and resources*. Sometimes planning groups recreate programs, services, or resources that already exist and could be built upon or used as adjuncts to newly created programs. It is important to identify existing prevention programs and assess them in terms of whether they offer primary, secondary, or tertiary prevention. Planning groups can then determine how to focus new initiatives (i.e., primary, secondary, or tertiary) and do a better job of effectively utilizing newly committed funding and resources.
7. *Carefully describe policies and procedures*. Before implementing a new program, it is extremely important to draft a description of all policies and procedures to be followed. This insures that everyone involved in the program can be clear about roles and responsibilities. A written description also provides opportunity for input, revision, and refinement. Program descriptions can (and should) be checked in advance of implementation for legal and ethical implications.

8. *Plan variations for diversity.* For many young people, minority status is associated with low socioeconomic status, poor living conditions, fragmented families, and a variety of critical cultural, ethnic, and racial differences. All human service specialists must be flexible about making adaptions in prevention programming in a way that shows sensitivity and respect for diversity. Variations for diversity are addressed throughout this edition of *Youth at Risk*.
9. *Plan staff development.* Whether prevention programming is centered in school or community settings, all staff need to be educated, supervised, and prepared in advance of program implementation. Adults working on behalf of children and adolescents need to be carefully prepared and provided with opportunities to have their questions answered and their concerns addressed.
10. *Make sure adjunct services and referral options have been identified.* Those working on behalf of children and adolescents often need the assistance of other medical and social service professionals. Identifying adjunct services and referral options and acting as a liason with employees in those settings, in advance, should never be overlooked.
11. *Plan evaluation procedures prior to program implementation.* Practitioners often neglect the evaluative component of prevention programming efforts. Evaluation procedures should be preplanned, and data collection should be an integral part of efforts on behalf of youth. Data can be used to modify and improve the services offered and can provide justification for continued funding and commitment of other needed resources.

## SUMMARY

Our overview of prevention has provided introductory material highlighting the problems that underscore the need for escalation of prevention efforts; defined the qualities of prevention programming; described the differences among primary, secondary, and tertiary prevention and noted the need for additional primary prevention programs; and suggested guidelines and steps for prevention programming. We hope that this information provides an enriched perspective with which to approach the material in the chapters that follow. The context of this chapter is reflective of our belief that more emphasis needs to be placed on proactive prevention efforts so that, as time passes, individuals, families, schools, and communities can lessen the amount of time and energy directed toward remediation and containment of impairment and dysfunction.

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# II

# EXAMINING THE CAUSES

Building on the foundational information in Part One, the five chapters that compose Part Two provide current and comprehensive information regarding the factors generally considered to be causal to the development of at-risk behaviors. It is important to keep in mind that it is impossible to draw a direct cause-effect relationship between any one of the five factors identified and any of the eight specific behaviors identified in Part Three of this text. Thus these causal factors must be viewed as both cumulative and cyclical. This view helps to develop our awareness that taken separately any one of these causal dimensions enhances the likelihood of at-riskness in youth. Further, when viewed from a cumulative and cyclical perspective, the development of at-risk behaviors is almost inevitable.

Chapter 3, The Harmful Effects of Dysfunctional Family Dynamics, spells out the gradations of family dysfunctionality and highlights the discussion with case examples. Causal factors within the family dynamic that enhance the possibility of at-riskness in youth are discussed and also highlighted with case examples. These factors include at-risk parents rearing at-risk youth, parental conflict, family development, intrusive parents, and serious family illness. The chapter ends with a discussion of prevention approaches aimed at ameliorating the identified causal factors.

Chapter 4, Body Violation: Physical and Sexual Abuse, provides information on the demographics of physical and sexual abuse and the long-term effects of this abuse. The causal factors that perpetuate this type of behavior and descriptions of the youthful offender provide the background for the presentation of both prevention and intervention strategies to deal with this area from family, school, individual, and community perspectives. The challenge that ends this chapter is for all persons concerned with youth.

Chapter 5, Who Cares What I Think: Problems of Low Self- Esteem, focuses on a causal factor that permeates any discussion of at-risk behaviors. Information in this chapter includes not only definitions and indicators of low self-esteem but also causal factors from parental, social, physical, environmental, and cultural perspectives. Prevention approaches are presented from individual, school, community, and global perspectives and applied in a case study.

Chapter 6, Depression in Childhood and Adolescence: Working to Prevent Despair, illuminates the complex issues of both definition and diagnosis. The case study of Esteban is used to provide information dealing with causal factors from biological, psychodynamic, behavioral, cognitive, and family perspectives. Family, individual, school, and community approaches to prevention and treatment programs are discussed. A presentation of comprehensive intervention approach to treatment concludes the chapter.

Chapter 7, Stress and Coping in Today's Society, describes the confusion surrounding the definition of stress and delineates three perspectives on the stress concept: stimulus-oriented views, response-oriented views, and stress as a transaction between the person and the environment. Types of stress factors that may have a causal relationship to the development of at-risk behaviors are presented. Approaches to prevention from family, school, individual, and community perspectives conclude the chapter.

# 3 The Harmful Effects of Dysfunctional Family Dynamics

*Artis J. Palmo and Linda A. Palmo*

The problem of youth at risk is not new, but rather the use of a relatively new phrase to describe an old problem of long standing. The Pennsylvania Department of Education (1987) described at-risk students as those who run "the risk of not acquiring the knowledge, skills, and attitudes needed to become successful adults. . ." (p. 1). This description is quite profound when considering the at-risk youth from a family perspective. If parents have been unable to acquire the "knowledge, skills, and attitudes needed to become successful adults," how destined are their children to be youth at risk? If youth are at risk, are parents also at risk? For that matter, can entire families be at risk?

The basic premise for this chapter is that the at-risk behaviors exhibited by youth are a direct result of dysfunctional family dynamics. Note in the case studies presented throughout the chapter that the at-risk youth is frequently a representation of the chaos, disruption, and pain in the family as a whole. Parents, in reaction to the problems presented by the at-risk youth, may attempt to find simple solutions to complex questions, avoiding the possibility of exploring or admitting their own dysfunctional family dynamics to themselves or any helping professional who may be involved with the at-risk youth.

The literature (Abbott, 1978; Anderson & Limoncelli, 1982; Conger & Conger, 1994; Cummings, Davies, & Simpson, 1994; Cumsille & Epstein, 1994; Fincham, 1994; Kitzman & Emery, 1994; Kunisawa, 1988; Perkins & Berkowitz, 1991; Stevens & Pihl, 1982a, 1982b; Zarb, 1981, 1984) describes a multitude of characteristics, attributes, and reasons for at-risk status. Gadwa and Griggs (1985) categorized these into four areas in discussing the development of at-risk behaviors of youth: family, personal characteristics, socioeconomic factors, and school behavior. Although the study referred primarily to at-risk status of potential high school dropouts, their categorization can be generalized to all at-risk youth, regardless of the primary presenting problem. Two implications pervade these studies of at-risk youth. One is that family dynamics and patterns of interaction are a key reason for the development of at-risk status. The other is that the problems and characteristics of at-risk youth are multidimensional and seldom come from only one source.

The interaction of family dynamics and family background mixed with a multitude of other social factors provides the medium for the at-risk youth's inappropriate or maladjustive behaviors. The problematic dynamics in the family of the at-risk youth are multidimensional and can range from mild to moderate in severity. But it is not unusual for multiple problems to exist in the home (Fincham, 1994). The at-risk behaviors of youth are demonstrated in all types of families: rich and poor, blue collar and white collar, two parent and single parent, educated and uneducated. No family is immune to the potential for dysfunctional family dynamics.

## LEVELS OF DYSFUNCTION IN THE FAMILY

When examining and assessing the level of dysfunction in the family and the level of risk the youth exhibits, it is possible to classify families as either severely or moderately dysfunctional. The extent and type of treatment to be used with the family depends on the severity of the dysfunction in the family. Severely dysfunctional families are usually identified easily, whereas many moderately dysfunctional families become expert at concealing family difficulties. Before treatment can begin, an assessment of the dysfunctionality must be made in order to determine the most appropriate and beneficial plan to resolve the problems presented and those hidden by the family. The following discussion provides some distinctions between the severely and moderately dysfunctional families in order to assist in developing the skills needed to develop effective treatment plans.

### Severely Dysfunctional Families

In the severely dysfunctional family, the at-risk youth is predictable because of the severe dysfunction of one or more adults in the family. The adult(s) in the family may have been dysfunctional in the past or may presently exhibit many at-risk behaviors. For example, the adult(s) may have a poor work history, a criminal record, or a history of substance abuse. Frequently, the behaviors exhibited by the at-risk youth are identical to those exhibited by a parent at some point in his or her life. For example, the pregnant teenager often has parents who had to get married; the suicidal youth may have had a parent or grandparent who tried to commit suicide; or the anorectic young girl may have a mother who was or may be anorectic.

Underlying all of these difficulties and at-risk behaviors is a lack of rules and personal boundaries on the part of the adults as well as the youth. Frequently, the adults have fewer boundaries than the children, with the children acting in the role of a parent to their own parents. An example of this is parents who use drugs in front of the children, come home drunk, and do not go to work—and have children who, because of their inappropriate sense of responsibility and lack of structure and healthy boundaries, have not been attending school, have been caught with drugs, and are failing the 11th grade! Treating the at-risk youth has to involve treating the parents of severely dysfunctional families. The parents will have to face their problematic behaviors before the at-risk youth can face his or her problems.

The case of Allison helps to demonstrate the need for parental change in behavior before a youth can begin to reconstruct his or her life:

> Allison was a 16-year-old with a long history of school failure, drug and alcohol abuse, and delinquent behaviors. She lived with her mother and stepfather, maintaining only minor contact with her biological father. Because of the many difficulties faced with raising Allison, her parents decided to send her to a structured private school, hoping to resolve many of the issues they faced with her.
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> Her mother and stepfather were both currently alcohol abusers and had been drug abusers in the past. On more than one occasion, Allison and her mother smoked marijuana together. The marriage was very much in upheaval, with the two adults having frequent battles surrounding Allison's behavior and how to parent her. In addition, the two had many battles about the way money was to be spent at home. Overall, the marriage was in deep trouble.
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> Eventually, as school approached, Allison ran away on several occasions, only to return home when she had no money. Her drug habits became so involved that upon her final return home, she was committed to a drug rehabilitation facility. During this time, her parents sought some counseling, but never committed to repair their marriage or to stop their own addictions, which included excessive drinking, overwork, and overspending.

The case of Allison demonstrates many of the treatment dilemmas faced with severely dysfunctional families. One is that unless the parents are willing to change some of their severe, destructive behaviors, the youth will never change their at-risk behaviors. Another is that the youths' behaviors are most often represented in the behaviors of the adults responsible for them. In Allison's case, her parents were involved in their own addictions, and unless they gave up their addictions, a change in Allison's behaviors was highly unlikely. Further, the marital discord played a major role in Allison's life, with the highest level of cooperation between her mother and stepfather occurring when she is in the most trouble. In fact, Allison's problems kept her mother and stepfather together.

Rules and personal boundaries are the key issues to be considered in assessing the severity of the problems the at-risk youth and dysfunctional family exhibit. The higher the level of difficulty with rules and boundaries, the greater the level of risk and dysfunction. In addition, the more difficulty the adults have with rules and boundaries, the greater the risk for the youth. Therefore, the adult who constantly abuses drugs and alcohol, like Allison's parents, has little understanding of the importance of basic daily responsibilities and parenting. The at-risk youth has a difficult time finding appropriate role models in the home where he or she lives. The youth perceives parents as constantly repeating, "Do as I say, not as I do!" Treatment of the severely dysfunctional family is difficult. If the parents cannot or will not participate in changing the problematic family dynamics, the prognosis for improvement of the at-risk youth is poor.

One final point about Allison needs to be made. As already mentioned, the severely dysfunctional family can be seen at all socioeconomic levels. Allison lived in a house where her mother was physically available to her each day and with a stepfather who was a doctor. Her biological father was an engineer, and her stepmother a professional business women. Even though Allison had her share of acceptable role models and high socioeconomic status, she could not override the severe dysfunction demonstrated from within her family.

## Moderately Dysfunctional Families

In the moderately dysfunctional family, the at-risk status of the youth is more difficult to discern and is not so readily apparent to the outside world. The personal profile of the at-risk youth is more difficult to interpret because of the seeming stability of the family. Each parent presents an appropriate image to the outside world; therefore, it is difficult to believe that there may be severe problems with one of the children. Below the surface, hidden from the community view, the family has difficulties it is not willing to reveal. The at-risk youth becomes the not-so-popular messenger, letting the community know that the family has secrets and is not perfect. There are flaws in the family photo, and the picture glass is cracked!

The advantage to the professional treating the moderately dysfunctional family is that the adults are typically able to function pragmatically on a day-to-day basis. Usually, they are competent in dealing with their job, in paying taxes, and in generally following the rules. However, just as in the case of Allison, the adults have difficulty following the rules of marriage and parenting.

The case of Josh helps to demonstrate:

> Josh was a 16-year-old high school junior who was failing several school subjects and at times was quite depressed. He was brought to counseling

by his mother and father, who were both professionals. The parents were quite concerned and willing to do what was necessary to have Josh be more successful and happy. Josh's father had a bad temper and frequently argued with Josh, while his mother tended to be the peacemaker. Mother always sided with Josh against father, causing significant problems between parents.

During family counseling and marriage counseling, the patterns of communication, parenting lapses, and spousal nonsupport were discussed at length. Eventually, Josh's parents began to understand the need for cooperation between themselves if there was to be any change in Josh. After several months, Josh's father quit the violent arguments with him, and began simply to talk with Josh rather than yell at him. Mother no longer took Josh's side during arguments and did not undercut father's attempts to discipline. Josh eventually quit using one parent against the other to get his way and began to establish a relationship with his father.

Unlike Allison's parents, Josh's parents understood the need to make changes and made a commitment to do so. Even though Allison's parents knew what needed to be done, they would not make the necessary changes. The prognosis for the youth from the moderately dysfunctional family is better because the parents can more easily change some of their behaviors, including improving their parenting skills. The greatest problem is having the parents accept their portion of the responsibility for the dysfunctional family dynamics and not keep the focus solely on the youth. Allison's family needed her to be dysfunctional because the family could not function any other way; but Josh's family knew a change in the entire family system was needed for everyone's—especially Josh's—benefit.

## CAUSAL FACTORS

It is important to examine some of the factors that contribute to patterns of behavior in dysfunctional families and lead to destructive behavioral patterns in at-risk youth. Dysfunctional family systems create an emotional atmosphere for at-risk youth that produces severe personal stress and emotional upheaval. The highly charged emotional atmosphere causes the at-risk youth to accommodate his or her behavior in such a way as to reduce the internal stress and upheaval. Accommodating the stress and upheaval creates problem behaviors such as poor school performance, depression, anorexia, loss of control, and myriad other at-risk behaviors. This section examines many of the factors that produce emotional conflict for youth, including parenting by at-risk adults, parental conflict, family denial, parentification, intrusive parents, and serious illness.

## At-Risk Adults Parenting At-Risk Youth

Some of the most important information to be obtained upon identifying an at-risk youth is the complete history of the family members, especially the parents. Knowledge of past pathology manifested by the parent or parents is frequently most helpful in the diagnosis and treatment of the youth. An awareness of the parents' problem can significantly help determine the direction and depth of the problem exhibited by the youth. Although the behaviors of the adults may be different from those of the at-risk youth, the goal of the behavior remains the same: direct or indirect self-destruction (Farberow, 1980). For example, an adult's self-destructive tendencies often entail making decisions that are not personally or professionally productive rather than being suicidal.

The case of Bob and his family demonstrate this:

> Bob was a 45-year-old father of two who had been married for 24 years to Terri. Both were professional people with highly responsible jobs. Bob had a severe drinking problem that had affected the family for years and that he had refused to address either through hospitalization or Alcoholics Anonymous. The two daughters, ages 17 and 19, were both high achievers in high school, receiving various scholarship offers for college. When the oldest daughter, Mary, went off to college, the family pathology finally began to manifest itself.
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> Mary found it impossible to remain at college and live in the dorm. She returned home after only 2 weeks to work and try to determine her next step. After being home for the entire year, she applied to another college and went off once again. Needless to say, she could not stay at the new college either, returning home after only 2 days. At about this time, her father had a severe alcoholic episode and had to be brought home in a taxi one evening because of his drunkenness. He fought with his wife and destroyed the house before being hospitalized for several days. He checked out of the hospital before treatment was completed and against medical advice.
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> Mary's reaction to all of the confusion in her life was to take a bottle of pills. Her attempt at suicide was a cry for help that almost cost her her life. In trying to fix her parents and their marriage, she became unable to control her own life.

There are numerous at-risk behaviors that adults demonstrate to their children, and certain behaviors in their past tend to influence their interactions with the youth. Those adults who exhibit at-risk behaviors, such as Mary's father, more than likely exhibited at-risk behaviors as youth. As adults, they find themselves faced with children who now exhibit various forms of at-risk behaviors.

The case of Mary demonstrates several important points. One is that the father's severe drinking problem (Perkins & Berkowitz, 1991) directly affected the behavior of his at-risk daughter. Another is that by never "getting her life together," Mary avoids leaving home and abandoning her parents for whom and to whom she feels responsible. Mary is "saving" the marriage and family (Lopez, 1991) by putting herself at risk. In this instance, the at-risk parent is the direct cause of the at-risk behaviors of his daughter.

Yet another important point is that the transmission of at-risk tendencies from parent to child is much easier to assess with the severely dysfunctional family. The at-risk tendencies become hidden in moderately dysfunctional families; therefore, the mental health professional must be astute and persistent in probing to find the hidden at-risk behaviors of the adults. The lawyer and his wife, the professor and the saleswoman, or the successful business owner and his wife the doctor are not going to admit to their problems as easily as those families with known histories of alcohol or drug abuse.

## Parental Conflict and the At-Risk Youth

If parents are having difficulty processing conflict between themselves, the situation is likely to deteriorate into communication problems between the parents and extend to communication problems between parents and child. Secrets begin to exist between the parents, and the at-risk status of the child may be hidden from view by the poor communication of the parents. In the conflict between parents, the children become the emotional pawns in the intensified atmosphere of the home (Fincham, 1994; Fincham, Grych, & Osborne, 1994; Lopez, 1991; Rutter, 1994; Thompson, Entwisle, Alexander, & Sundius, 1992). For example, Rutter (1994) contended in his research that family conflict is a direct correlate of conduct disorder behaviors in the children.

The conflict between the parents leads to power struggles in parenting the child. Each parent attempts to structure his or her relationship with the child as an individual instead of as a member of the marital unit. Loyalty issues are pressed onto the child. For example, a teenager comes home after curfew and is grounded for a week by the father. After 2 days mother allows the teenager to visit friends but says, "Don't tell Dad!" This pattern of deceit between parents empowers the at-risk youth in two ways: the youth learns not to follow rules, and the youth learns to be deceitful. As family functioning begins to deteriorate, the youth will begin to demonstrate greater and greater maladaptive behavior (Cumsille & Epstein, 1994).

The case of James illustrates:

> James was a 16-year-old sophomore in high school who was in frequent difficulties at school and in the community. The level of inappropriate

> conduct was never very severe until he made an attempt to commit suicide. At that time, James' parents were forced to enter counseling in order to assist him through this difficult time. It was immediately evident that the parents had a long history of marital and parental discord. James' father was upset with his mother over numerous issues, including an affair, overspending, poor discipline of the children, and meddling in-laws. All of these issues played into the conflict between the parents, obviously affecting James' behavior at home and at school. His ultimate reaction to the conflict, an attempt to bring the family and parents back together, was to become self-destructive.

Several important points about the struggles faced by at-risk youth are demonstrated in the case of James. First, it is difficult, if not impossible, to discipline and parent a youth having severe difficulties without complete cooperation between the parents. One parent undercutting the effectiveness of the other makes it impossible to bring about change in the family and creates a situation where the youth can become at risk. Second, loyalty issues between family members can create severe problems if the loyalty lines are inappropriately drawn (Visher & Visher, 1988). A youth who is dependent upon one parent can become angry at the other parent and attempt various at-risk behaviors, such as suicide. The family tensions can cause the youth to make inappropriate decisions and engage in self-destructive types of behavior (Cumsille & Epstein, 1994).

Third, the parent conflict that results in divorce is important—and prevalent—in today's world. To oversimplify a difficult and complex problem, let us say that a divorce happens when two people fail to communicate and resolve conflict. Following divorce, if a youth exhibits at-risk behaviors, it usually takes a significant problem to force the parents to face the severity of the issues. Kitzman & Emery (1994) reported that the parental conflict after divorce is a significant problem for the children. Children express their concern over the conflict in inappropriate, at-risk behaviors. It is apparent from Kitzman & Emery and our own practice that divorce creates a situation in which the children need to be considered at risk immediately, and treated in a preventative fashion by the family, school, and community.

## Family Denial and At-Risk Youth

The defense mechanism of denial consists of a process of not seeing problems or their intensity. During times when problems become evident, denial allows people to blame others rather than themselves. Therefore, denial can be acted out in two ways in families: by "burying one's head in the sand" and not wanting to see the reality of the situation, and by "finger pointing" and blaming others for one's problems. Both methods of using denial lead to the potential for the youth to become at risk. The case of Kathy attests to the effect of denial on the development of at-risk youth:

> Kathy was a 17-year-old senior who had become more and more defiant at home with her parents. The parents attributed the defiance to Kathy's boyfriend of the past 8 months. She began to stay out beyond her assigned curfew, her grades at school declined, and her attitude at home became increasingly negative. At various times over the end of her junior year and the beginning of her senior year, Kathy became ill and unable to work or attend school. Her parents suspected that she was pregnant, but Kathy denied that she was. Throughout this period of time, the parents were concerned about Kathy's relationship with her 20-year-old boyfriend, frequently having violent arguments because they wanted her to see him less or break off the relationship.
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> During the second month of her senior year, Kathy had a baby. The parents never knew she was pregnant until the night Kathy's water broke at home. After being rushed to the hospital, Kathy gave birth to a severely deformed baby who lived only several months. During this time, the parents and Kathy continued to battle over the relationship with the baby's father.

This tragic case presents the ultimate example of denial of a major problem while focusing on a serious, but tangential, problem. Kathy's parents ignored the issue of the pregnancy, even though they strongly suspected something was physically wrong with their daughter. Rather than having their daughter be examined by a physician, the parents went along with Kathy's denial. Instead of directly confronting issues with the youth, parents tend to allow them to have the power over major decisions in their lives. The parents wanted to believe that Kathy was fine and did not want to risk a battle with Kathy. But by not wanting to see the reality of the situation, by denying that anything was wrong, they placed their daughter at risk. If the parents had become involved earlier, the tragedy might have been avoided.

Further, because the parents could only focus on Kathy's relationship, they could not see the larger picture. Kathy's relationship with her boyfriend was symbolic of the gap in the relationship between herself and her parents. The parents had lost control of the relationship with Kathy. By not examining their problems, by affixing all blame to the boyfriend, they denied their responsibility and worsened their child's at-risk situation.

Mental health professionals must be willing to examine the issues behind the presenting problem(s). Frequently, the obvious problem is actually covering or disguising the real problem(s), as in Kathy's case. Sadly, at times the denial will cease only following some type of personal tragedy in the youth's life.

## Parentification of Children

One pattern of dysfunctional family dynamics that begins in the early years of child development is parentification of children. The pattern arises when parents give responsibilities and privileges that are more appropriate for older children or adults to younger children. These parentified children are given the power to make decisions that belong with the parents. By their actions and requests, the children control the household and frequently dictate the mood of the entire family. Parents, fearful of disrupting the family calm, refrain from effective discipline techniques. But by giving the power to the child, the parents abdicate their responsibility for protecting the child from potentially dangerous situations.

The case of Ray helps to demonstrate this important point:

> Ray, a 10th grader, was referred to the Student Assistance Program when he was overheard saying to another student that he wanted to die. His parents were contacted and referred for counseling. Ray objected to the counseling and said he would not go to see anyone. The parents contacted the counselor and asked for a suggestion as to how they could force him into counseling. The counselor told them to tell Ray he had no choice in the matter and that he had to go to counseling. This approach worked, and Ray and his family appeared at the counselor's office for help.
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> Ray was seen for three sessions alone and in one family session. After these sessions, the counselor provided feedback to the family and suggested that Ray remain in counseling to deal with his depression, mood swings, and suicidal tendencies. The counselor also told the parents that some family counseling in conjunction with individual counseling would help them deal with Ray more effectively. After the feedback session, the mother and father said they would let Ray decide because the counseling was for him! Even though they were told about Ray's depression and suicidal ideation, they felt Ray had to make the decision because they did not want to have to "fight" with him to get him to attend counseling sessions.

In this example, the well-being of the child was left with the child. The parents did not take control of the situation. By permitting the child to make such decisions, the child's at-risk status increased significantly. Parentification applies not only in such dramatic cases as Ray's but also in such other areas as school achievement, dating, drugs, alcohol, and crime.

From our experiences, the parentification of children happens quite frequently in divorced situations. As the conflict between divorcing parents escalates, more and more self-care is left with the child, which leads to parentification. In some instances, very young children are expected to carry the burden for maintaining the well-being of the parents during the separation and divorce process. As long as the child is behaving well, giving attention to the parents, and causing no apparent difficulty, life is fine. The burden can become intense as the child grows and matures. It is tiring to always be happy, provide love for a parent, care for other children, and be adult-like. In these cases, the parents report that the child has never been a difficulty, but rather the ideal child who always took care of everything.

Children and youth want to be in control of the decisions that affect their lives and will take every opportunity to gather more power. Parents must be encouraged to involve their children in the decision-making process, but involvement is different from making a final decision. Final decisions belong to the parents, not the children. When the child makes the choices alone, then he or she is more than likely at risk.

## Intrusive Parents and the At-Risk Youth

The intrusive parent gives the youth absolutely no privacy, checking everything from the mileage on the car to bedroom belongings for clues to the youth's inappropriate activities. Typically, the intrusiveness begins when the youth has broken the trust of the parent-child relationship by being caught drinking, stealing, lying, coming home late, or with marijuana. After one or two of these "crimes," the youth's life is no longer private but becomes a public domain. In some instances, checking on the youth for possible signs of acting out that can be dangerous to the youth's well-being is a good idea. However, the intrusive parent goes far beyond simple observing to checking pockets in dirty clothes, going through notebooks from school, checking mail, and reading notes from friends.

The intent of the intrusiveness by the parent is to help reduce the probability of the youth doing something wrong or dangerous. However, the opposite usually happens, with the youth becoming more secretive and taking more risks to keep his or her activities from the parents. The overemphasis on the parent-child relationship can be an indication that something is wrong with the marital relationship. As a result, the at-risk youth becomes an extension of the conflicts between the parents. The youth's goal is to force the parents to deal with the real issues surrounding the marital and family disruption.

Another way intrusive parents have difficulty with boundary issues is in attempting to protect the youth from the natural consequences of his or her actions. The protectiveness of the parents arises from the guilt they feel about the lack of stability in their marriage, from the ineffectual way they have handled their lives, and from the failure they feel as parents. Whenever the youth has a problem, the parents attempt to fix it rather than letting the youth suffer the consequences for his or her actions. Parents complete homework, pay the cost of damage to cars, and lie to the school about absences. All of this raises the at-risk status of the youth rather than reducing the concerns that brought about the intrusiveness.

## Serious Illness Within the Family

Another family system relating to the causes of at-risk behavior is the family faced with serious illness, such as cancer, heart problems, diabetes, or other similar life-threatening problems. Within this family structure, the family never completely or openly discusses the problem or is open about the extent of the difficulties the problem may cause the individual or the family. For example, a youth may learn from his biology class or health instructor that the serious heart ailment his father suffers has a genetic link. If the family has not discussed the future implications with the children, the impact of such information on the youth can be traumatic. The youth, upon learning such crucial information, must be considered at risk.

The lack of communication about the serious illness promotes a family system that, on one hand, is based in secrecy, deceit, and dishonesty but, on the other, is emotionally charged. Family members tend to overreact to simple problems, parents are protective of the children, and in general, the entire family is oversensitive (Kazak, Christakis, Alderfer, & Coiro, 1994). However, the sensitivity and emotionality are related to the serious illness, which is rarely discussed, while attention is placed on less serious problems and concerns. Denial is a major aspect of this dysfunctional family system.

The case of Jeff demonstrates the high at-risk status of children suffering severe health problems:

> Jeff was a 5-year-old who was brought to the hospital for various health problems. In the emergency room doctors discovered that he had a severe case of diabetes. Needless to say, his mother and he were stunned, with both having great difficulty believing this was going to be a lifelong problem. At age 5, Jeff was going to need a very strong and supportive family in order to handle the daily care needed to keep him healthy. However, upon meeting Jeff's mother, the counselor learned that she was divorced and remarried, with a poor relationship with both her first and second husbands. Ensuring good care for Jeff was going to be quite difficult because the adults in his life were unable to make effective decisions without a major battle.
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> Jeff remained in shock over the whole ordeal, not really believing that he would no longer be able to eat sugar from a bowl or have all the candy he wanted. Jeff tried to bargain the problem of diabetes away. He asked the counselor, "If I eat right for 6 months, the problem will go away and I won't need insulin shots?" The counselor told him that the answer was

> "No" and that he would always need the insulin and be on a special diet. Then Jeff asked, "If I'm good for 2 years, it will go away?" Once again, the counselor told him "No." His mother had the same problem and could not be honest with Jeff because she wanted to protect him.

As the case of Jeff demonstrates, the family faced with a serious illness certainly has to juggle many emotionally charged issues. In most instances, problematic family issues that existed before the medical crisis become exaggerated and of larger importance. As with Jeff, the boundary issues faced by the mother in parenting him are exacerbated by the illness. Any child with a significant health concern can be an at-risk child if he or she has parents who do not know how to manage such an overwhelming problem. The family with a seriously ill member needs much support from the community at large.

## PREVENTION

Prevention is a major part of the mental health services to be provided for the at-risk youth and those individuals associated with the at-risk youth. Handlon and Palmo (1986) defined prevention as an early intervention "...in the sequence of stages of the development of a problem" (p. 347). Prevention interventions are aimed at normally functioning individuals and groups with the goal of stopping maladjustments before they occur.

Understanding the three levels of prevention as presented by Goodyear (1976) is important when examining prevention programs in relation to at-risk youth. These levels are primary, secondary, and tertiary. Primary prevention is aimed at the development of special education programs and presentations aimed at the general population. Secondary prevention involves specific interventions such as crisis counseling, marriage counseling, or family counseling for the at-risk youth and family. Secondary prevention is usually aimed at minor crises and maladies. Tertiary prevention attempts to rehabilitate the individual who suffers chronic, severe problems. Tertiary programs are usually viewed as being beyond the typical conceptions of prevention.

This section discusses family, individual, school, and community interventions that can be categorized as secondary prevention. Note, however, that primary prevention programs are much more difficult to define, design, and implement. Primary prevention programs must be viewed as marketing ventures in which the counselors and educators are attempting to sell a product emphasizing the need for preventive measures. In primary prevention, the counselor is the marketing specialist who has the major responsibility of researching, designing, field testing, and implementing programs aimed at preventing problems. Needless to say, this is not an easy task for any professional.

Drum (1984) presented a 10-step outline for the professional attempting to develop a prevention program:

1. Know the consumer population;
2. Present a personalized message to which the individual can attach;
3. Develop and work toward concrete goals;
4. Present a creative message with which the consumer can identify;
5. Provide the information honestly, but don't terrify the population;
6. Activate the program prior to the problem becoming a crisis;
7. Have the supportive programs in place once the prevention information is activated;
8. Present the information at a slow pace so that the population is not overwhelmed;
9. Provide a feedback mechanism for participants; and
10. Create a program that is realistic and reasonable.

With these points in mind, this section attempts to provide some ideas about serving at-risk youth. The most important aspect about prevention is that the individuals and groups serving at-risk youth need as much education and assistance as can be possibly given by the mental health professionals providing direct interventions. Teachers, community agencies, coaches, bosses, parents, and grandparents all need to be given information on the telltale signs of problems demonstrated by youth.

## Family

When an at-risk youth is identified, much attention is often given directly to the youth without commensurate attention to the entire family. Without the involvement of the family, there can be several major problems.

One is that assessing the level of risk for the adolescent without understanding his or her position or role within the family unit is impossible. How the youth begins to feel "out of place" within the family (Conger & Conger, 1994; Cummings et al., 1994; Dinkmeyer, Dinkmeyer, & Sperry, 1987) certainly influences how the youth feels out of place in the world at large. The problems expressed by the at-risk youth are often a direct result of difficulties experienced either overtly or covertly by the family unit (Cumsille & Epstein, 1994). Therefore, involving all family members in the process of assessment often prevents an inappropriate treatment plan.

Another problem is that there is often an assumption that the at-risk youth is the identified problem in the family. In truth, the at-risk youth is a representative of the family (Perkins & Berkowitz, 1991; Rutter, 1994; White, Taylor, & Moss, 1992) and symbolizes the severity of the difficulties within the family unit. The greater the difficulties demonstrated by the youth, the larger the number of issues that need attention within the family. It is inappropriate to assume that the identified problem child is the only family member with mental health needs or the only family member who may be at risk.

The case of Justin illustrates:

> Justin, a 14-year-old high school freshman, was referred for counseling by his school counselor following the interception of a suicide note. Two of Justin's friends found a letter describing how he planned to shoot himself. Justin, along with his mother and father, came to counseling. It was apparent in the initial session that Justin did not want to be there. He was rude, obnoxious, and embarrassing to his parents. Mother was tearful while father remained stoic. Both parents were obviously shaken by Justin's recent behaviors. The counselor attempted to understand the relationship between the issues Justin expressed and the problems that the family faced, but no clear correlation emerged. Justin's behaviors were so disruptive that it was difficult to have his parents in the counseling session. Although several more counseling appointments were set up, the mother called the next day and canceled them.
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> Two weeks later the counselor received a call from the mother asking for help. Her husband had been placed in the psychiatric unit of the local hospital. She explained that her husband had been laid off from work for the last 6 months and was becoming more and more withdrawn. He seemed devastated by the problems with Justin. In despair, he pulled out his shotgun and threatened to kill himself. Justin's mother called the police, and eventually her husband was placed in inpatient psychiatric care.

The case of Justin demonstrates the importance of assessing and involving the entire family in the development of a plan of action. The at-risk youth often has a position of power and parentification in the family (Palmo & Palmo, 1988). Because of the focus on the at-risk youth, it is often easy to miss other significant family dynamics. A thorough family assessment often prevents the possibility of at-risk behaviors in other family members and assists in diagnosing other mental health needs of the family.

Yet another problem that may arise without the involvement of the family is that once the youth demonstrates at-risk behaviors, family dynamics play a significant role in whether or not the at-risk behaviors will escalate or decrease. If the dysfunctional aspects of the family dynamics are not identified, discussed, and changed, the behaviors of the at-risk youth will continue to escalate. It is common knowledge that conflicts between parents, whether overt or covert, have a significant impact on the behavior of the children. However, for the at-risk youth, the parental conflict has a compounding effect (Conger & Conger, 1994). Whereas one child in the family may choose to ignore mother's and father's problems by spending more time with friends or putting excessive energy into school, the at-risk youth may react by drug and alcohol abuse, suicidal ideation, or behavioral problems in the classroom. Involving the family in the treatment of at-risk youth is necessary to prevent the escalation of at-risk behaviors.

Involving the family in the assessment, diagnosis, and treatment planning of the at-risk youth is also necessary. The counselor provides a model of behavior to the parent, and the parents provide a wealth of information, spoken or unspoken, to the counselor. Many counselors wonder which family members should be involved in the counseling process. It is important to consider all members of the household as potential participants in the work with at-risk youth.

Frequently, one of the most effective treatment modalities to bring about change in the youth is couples counseling. If the parents can commit to working on their relationship, along with being willing to learn different parenting approaches with their children, the chances of successfully assisting an at-risk youth increase significantly. As demonstrated throughout the case studies, frequently the relationship between the couple is in such disarray that it is easy to understand why the youth may be having emotional difficulty. Parents who work too much, drink too much, or allow their lives to be out of control provide an inappropriate model for the developing youth (Fincham, 1994). Once parents are taught to reorient and redirect some of their energies, the positive changes in the youth can be absolutely astounding. Therefore, couples counseling along with family counseling can produce tremendous changes in the dysfunctional family structure.

Family counseling must thus be part of the intervention and prevention plan for at-risk youth. In treating the family, the mental health professional must maintain a neutral position and avoid a position of being on someone's side. The youth and the parents will both attempt to enlist the counselor's support in their attempts to maintain the dysfunctional family system. The youth or a parent may make phone calls, bring damaging evidence to the session to demonstrate someone's problems, or ask for additional sessions to try to influence the counseling sessions. Remember that the goal is not to fix the at-risk youth but rather to support the development of a new and functional family interaction system.

## Individual

To understand the prevention of at-risk behaviors in adolescents, understanding the development of dysfunctional family dynamics is critical. If the family's problems do not begin with the at-risk status of their son or daughter, as exemplified in many of the case studies, how does a family become dysfunctional? It is important to recognize that the development of at-risk behaviors occurs over a long period of time and is the result of numerous unresolved issues and problems.

The roots of dysfunctional family dynamics spring from the lack of effective definition of roles and responsibilities in a family. At-risk youth have one common characteristic. Regardless of their identified problem behavior, they all violate the established rules of the home, school, or community.

The violation of standards and structure begins early in life and early in the development of family dynamics. If parents do not agree on parenting responsibilities, then discipline, rules, and responsibilities are poorly defined (Evans, Evans, & Meredith, 1993). Because of the parental conflict, the child becomes parentified early in life. If parents neglect to provide adequate supervision and attention to children, as mentioned earlier, the child is often given major choices much too early in life. The child is asked to make all the decisions about how to direct his or her life appropriately. Without a sense of parental structure, the child seldom understands what *appropriate* means. Consequently, a child may develop at-risk behaviors due to poor parenting or a lack of parenting.

Preventing the development of at-risk behaviors may require that the child find other role models and mentors in his or her own day-to-day experiences. At-risk youth sometimes find their own ability to develop appropriate roles and responsibilities from interactions with peers, school teachers, neighbors, and other community leaders. If at-risk youth are to change their pattern of behavior, they need to see an alternative way to live.

The role of the counselor, who provides individual counseling to the at-risk youth, must exemplify the importance of well-defined rules and responsibilities. In working with the at-risk youth, the counselor must be sure to *follow the rules* of the treatment process. Just as the at-risk youth attempts to alter the rules in other settings for personal gain, the youth will attempt to have the professional alter, change, and ignore the rules of the treatment process.

For example, the youth may have a simple request, such as asking the counselor to write an excuse to allow him or her to miss a class at school or be permitted to miss detention. Other, more critical violations of the rules may be requests for emergency appointments late at night or over the weekend. One high school counselor from a rural district spent 6 hours with a youth along a country road following a phone call requesting her help. It was considerate of the counselor but also very risky and ethically questionable. The youth did not *follow the rules* of counseling—attending the counseling session—in the appropriate location. One way to decrease the at-risk behavior is to emphasize and define the role of the counselor and the rules of the counseling process.

Another aspect of prevention within the individual counseling process is the determination of the severity of the at-risk youth's actions and interactions. Whether the youth is abusing alcohol, is pregnant, or is a runaway, the professional needs to determine the extent of danger to the well-being of the youth. With at-risk youth, we take very few risks because youth tend to be impulsive in their actions and prone to hurting themselves physically.

In determining severity, the counselor needs to be highly aware of the concept of duty to warn. This is prevention of the highest order. If the at-risk youth is a danger to himself or herself or to others, ethically and legally the parents must be alerted to the extent of the problem (Nicolai & Scott, 1994; Palmo, Langlois, & Bender, 1988). At the initiation of counseling, the at-risk youth and the family are both informed that any suspicious or questionable behaviors will be reported. Confidentiality and at-risk status are both clearly defined early in the process, reinforcing the professional's responsibility to follow the rules.

If there is any question about the level of severity of the behavior the youth exhibits, professionals need to follow a very cautious route and involve the parents. *Following the rules* may mean having a crisis team available to give the youth the appropriate treatment, including possible hospitalization. If the youth is suicidal, a coordinated professional effort may need to be utilized to resolve the problem. The sooner the at-risk youth is involved in treatment, the greater the opportunity for successful resolution and prevention of problems.

Thus at-risk behavior may frequently develop from poor parenting or a lack of parenting. The counselor serves as the key role model for at-risk youth. Although the family should always be involved in the intervention and prevention plan, there can be problems with this practice. At times the level of dysfunction in the family is so great that effective family counseling is almost impossible. When the relationship between the couple is questionable, the parenting skills are almost nonexistent, one parent is an alcoholic, or the parents are frequently absent from the home, developing a treatment plan is more complex. It may be necessary to emphasize individual counseling with the at-risk youth rather than family counseling.

An emphasis on individual counseling places even more responsibility on the counselor to *follow the rules*. In order to treat effectively the myriad difficulties of at-risk youth, the professional must maintain a high level of confidence. Treating the at-risk youth can be a substantial test of a counselor's self-confidence; therefore, appropriate attention must be given to taking special care against stress and anxiety to prevent counselor burnout.

## Schools

School teachers, school counselors, and school psychologists are often front-line soldiers in the war against at-risk behaviors. It is essential for all school professionals to have a basic understanding of the principle of duty to warn. Three additional principles are also essential to understand.

The first is the principle of parent consultation. All school professionals need to be comfortable with this principle. If a school professional does not contact parents regarding at-risk behaviors, the professional is assuming too much responsibility for the at-risk youth. Parents need to be encouraged to take responsibility for their at-risk children, and as already mentioned, the parents must become actively involved in the process of treatment and prevention as soon as possible.

Providing an effective consultation with the parents assists the family in understanding the necessary steps of the treatment process. The school professional making the initial contact with the family must understand the critical nature of his or her role. It is essential to provide the family with a clear understanding of the helping process. The initial consultation should be used to encourage and assist the family in receiving the most effective services possible. If the initial consultation is a positive experience, the family will more than likely be ready to pursue the necessary steps of the treatment process.

A second principle that school professionals need to understand is referral and networking. If the school professional cannot provide the at-risk youth with appropriate services, he or she must refer the at-risk youth and the family to an appropriate agency, institution, or private practitioner. Frequently, the at-risk youth is identified by school professionals, but the services required for treatment are offered elsewhere. Therefore, the schools must develop comprehensive referral relationships with local agencies, practitioners, and hospitals (Nicolai & Scott, 1994; Palmo, Langlois, & Bender, 1988; Palmo & Palmo, 1988; Tranel, 1994).

Maintaining a comprehensive referral network of helping professionals is probably one of the most important aspects of prevention as well as a major responsibility for school professionals treating at-risk youth. The network should include both medical and nonmedical mental health service providers. Specifically, referral sources need to include psychiatrists, drug and alcohol counselors, mental health counselors, clinical psychologists, marriage and family specialists, and, in some cases, the clergy. School professionals treating at-risk youth must have a thorough knowledge of the variability and comprehensiveness of various services in the community.

The third principle that school professionals must understand is the need to be thoroughly trained in the ethical and legal aspects of treating at-risk youth. Each professional needs to be fully aware of his or her responsibility to the youth and the youth's family. Corey, Corey, and Callanan (1988) have presented an excellent overview of the issues and concerns involved in treating at-risk clients. Whether it is through formal graduate or undergraduate programs or school district in-service programs, school professionals need this information to prevent at-risk behaviors and deter the effects of dysfunctional family dynamics.

Another aspect of the ethical and legal principles with at-risk youth is confidentiality versus keeping dangerous secrets. Too often school professionals maintain confidentiality without considering the ramifications to the youth as well as to themselves. Being direct and upfront with the youth about the types of information and behavior that are treated in a confidential manner versus those to be reported to the parents helps avoid potential problems later in the treatment process.

School professionals are thus often the key connection between at-risk youth and their families. It is essential for school professionals to understand the principles of duty to warn, parental consultation, referral and networking, and legal and ethical concerns. Using professional colleagues for support and consultation, making effective and necessary referrals of particularly difficult cases, and seeking personal counseling when the stress becomes too great are some ways a school professional can maintain a high level of self-confidence and effectiveness.

### Community

There are two goals of prevention of at-risk behaviors related to the community. The first goal in prevention is to be able to educate the general public about variation in family structures and individual difference. It is still difficult for many local institutions such as churches, hospitals, and other community organizations to make allowances for the various family structures such as blended families, single-parent families, interracial families, and dual-career families. If the at-risk youth is to be able to find surrogate role models in the community, it is important for the potential role models to understand the dysfunctional and nontraditional aspects of family life in the current culture.

The second goal of prevention of at-risk behaviors is successful networking among all community mental health professionals. As presented in a more comprehensive form elsewhere (Palmo & Palmo, 1988), we believe that professional networking is the only effective method for treating at-risk youth. Because the at-risk status can be defined in many varied ways, the mental health professional must have an effective network of other professionals in order to offer the youth and the family the best services possible. The network should include knowledge of runaway shelters, crisis intervention teams, support groups, hospitals, and outpatient services. Networking is a safeguard for the client as well as the professional.

## SUMMARY

This chapter provides an overview of the family issues related to the causes of the problems surrounding at-risk youth. Also included are ideas about how to best provide a program of prevention to assist at-risk youth and their families. In summarizing, for mental health professionals treating at-risk youth, several points should be emphasized.

First, there is no more difficult population to serve than at-risk youth. They tend to be more professionally demanding, emotionally draining, and behaviorally unpredictable. Counselors must learn to be direct and honest with the youth as well as their families. Counselors must learn to *follow the rules* in treating the youth and force those involved in the treatment process (parents, teachers, community resources) to also keep in line.

Second, the at-risk family is a very special entity and needs tremendous amounts of attention to keep it functioning without a tragedy. When treating the at-risk individual, the counselor has to always be aware of the remaining family members to make sure that another member does not manifest a severe behavioral difficulty. Consultation with other important adults surrounding the family members is required for effective treatment of the at-risk family.

Finally, treating at-risk youth calls for a professional to be involved with the community, school, and family. There is no place in the treatment process for the professional "Lone Ranger." Within the boundaries of professional confidentiality, the counselor must remain in contact with other professionals in order to best serve the at-risk youth. The biggest mistake made by good-hearted professionals is to assume too much individual responsibility for the at-risk youth and his or her family. Find a support system to assist in the treatment process and be sure to have a support system available for yourself. Maintaining physical energy and emotional balance is as important as any decision the counselor can make.

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# 4

# Body Violation: Physical and Sexual Abuse

*Robert H. Rencken*

> *Why? The question is asked again and again.*
> *Why is the fragile shell of childhood cracked, broken, or shattered by abuse?*
> *Humpty Dumpty is pushed off the wall. Who can put him together again?*

The complexity and pervasiveness of physical and sexual abuse swirl before us, almost daring us to try to arrest them. Both causes and effects are insidious and intangible—barely discernible at times and devastating at others. We look at the troubled or at-risk youth with one eye and see a victim; with the other eye we see an actual or potential offender.

The complexity of the problem, in fact, obscures our ability to define and quantify it adequately. What is abuse? Who is the victim? Where are the limits? How bad is bad? Who reports what to whom? The impact of abuse is difficult to measure because of varying incidence factors and varying effects. These effects may be felt immediately after the abuse or not until weeks, months, or years later. As this chapter makes clear, physical and sexual abuse are major risk factors for children and adolescents.

This chapter specifically looks at the incidence and effects of physical and sexual abuse, the youthful offender, and the dynamics of abuse (causal factors). Intervention strategies are reviewed for both immediate and delayed time frames. There is also a discussion of prevention of both physical and sexual abuse.

## INCIDENCE AND EFFECTS

We are at a point of using a new rule for describing incidence factors for both physical and sexual abuse: imagine the worst scenario, then accept the reality that it is worse than that. Despite the media hype that we suspect is overstating the problem (including the sensational issues of ritual abuse and "recovered memory"—Brown, 1991; Rencken, 1993; Wylie, 1993), several factors point toward underreporting:

- Much of the work with survivors and victims involves retrospective reporting, discussing past incidents that were never originally reported. This is particularly true in sexual abuse. These reports include relatively recent incidents that clearly would have fallen under mandatory reporting.
- Increasingly severe penalties for the offender, particularly again for sexual abuse, discourage children from reporting or testifying against a family member.
- We, as adults, are so uncomfortable with the problems that we would rather ignore them and not get involved.
- The victimization of boys (Lew, 1988) is particularly repressed by our societal sexist beliefs that only girls are victims, only boys are offenders, and boys can't cry (or tattle or feel or care) and have to learn to "take it."
- We frequently "blame the victim."
- Children are not believed.

Is there a greater incidence of abuse or is it just being reported more? In my clinical experience, the answer to both questions is "Yes!"—because of continued familial and societal instability.

Clearly, we are a society that continues to abuse, exploit, and victimize those who are less powerful. Unfortunately, the consensus is that children are too often the targets. But even when they are the targets, they are not the only ones to feel the impact. Child, family, and society all take the blows and feel the violation.

## Physical Abuse Incidence

In reviewing incidence studies in physical abuse, Justice and Justice (1976) reported a range of 37 to 63 cases of physical abuse per 100,000 children but cautioned that the number of reported cases was increasing. A later review of estimates noted ranges from 200,000 to 4,000,000 cases per year (Goldstein, Keller, & Erne, 1985). The American Humane Association (AHA) (1981) showed that 750,000 children were reported as abused or neglected and that there was an increase of 15.7% over the previous year. The AHA data showed that major physical injuries were reported most frequently in young children (less than 3 years old) and older children (12 to 16 years old), with about equal proportions of male and female victims.

## Sexual Abuse Incidence

Finkelhor (1984) reviewed incidence studies related to sexual abuse. Incidence rates, rather than actual numbers, are reported with rates ranging from 5% to 9% for boys and 8% to 38% for girls. Finkelhor effectively pointed out that even if no more than 10% of girls and 2% of boys were abused, clearly a conservative estimate, there would be over 200,000 new cases of sexual abuse each year. Using other research techniques, some investigators have identified an incidence rate as high as 20% in both males and females (Miller, Johnson, & Johnson, 1991).

We also know that sexual abuse is primarily committed by men (Bell & Weinberg, 1978; Finkelhor, 1979). Men abuse about 95% of female victims and 80% of male victims. The most common age for victims is 8 through 12 years, but with many cases outside that range (Finkelhor, 1984). Most female victimization occurs within the family, whereas boys are more likely to be abused outside the family (Finkelhor, 1984).

## Physical Abuse Effects

Most of us, despite our societal lethargy, are concerned about the children, the victims of physical and sexual abuse. Sometimes, the damage is obvious: the bruises, the scars, the ultimately violated, lifeless body. Most of the time, however, the damage is not so visible. Recent research clearly confirmed the effects of abuse. Physical and sexual abuse have been linked, for example, to illicit drug use in adolescents (Dembo, 1987) and multiple personality disorder, now known as dissociative identity disorder (American Psychiatric Association [APA], 1994; Coons, 1986).

Physical abuse, specifically, is thought to affect children by creating behavior problems and reduced social competencies (Wolfe & Mosk, 1983); lowered self-esteem, antisocial behavior, and suicidal tendencies (Galambas & Dixon, 1984); acting out, depression, generalized anxiety, extreme adolescent adjustment problems, emotional-thought disturbances, and helplessness-dependency (Farber & Joseph, 1985); fewer friendships, social skills, and empathy (Lamphear, 1985); aggressive tendencies (Graybill, 1985); and delinquency, depression, attachment disorders, and sexual abuse (Steele, 1986). Broader effects on intellectual, cognitive, social, emotional, and linguistic development were noted by Cicchetti and Beeghly (1987) and Cryon (1985). Neurological abnormalities were reported in 53% of a sample of abused children (Martin, Beegley, Conway, & Kempe, 1974). Children have also been observed to develop patterns similar to abusing parents (aggression, isolation, and lack of empathy) as early as 1 to 3 years of age (Main & Goldwyn, 1984).

Abused children have been noted to have little confidence in their ability to influence or have control over their own experiences, a factor that becomes critical as we think of prevention (Barahal, Waterman, & Martin, 1981). Among abusing parents, 30% to 60% say they were abused as children (Justice & Justice, 1976). The exact manner in which this cycle is created certainly varies from one case to another, but clearly the child receives messages that violence is necessary and productive—might makes right—and that children are powerless possessions of parents. These messages are apparently so strong that they overwhelm the logic that those adults who were abused as children should know better. The ultimate irony is that physical abuse may be the biggest cause and effect of physical abuse.

## Sexual Abuse Effects

The effects of sexual abuse specifically have been linked to difficulties in healthy sexual functioning and self-esteem (Burgess, Holmstrom, Groth, & Sgroi, 1978); runaway behavior and delinquent/criminal activities (McCormack, 1986); lowered confidence, fewer friends, more aggression, increased sexual awareness, and behavior and academic problems (Tong, 1987); binge eating (Jones & Emerson, 1994); and prostitution (Silbert & Pines, 1983). Women with depressive and anxiety disorders have also shown a high prevalence of sexual abuse victimization (Murrey et al., 1993).

The intergenerational effect in sexual abuse is less clear than in physical abuse, primarily because of its currency and lack of longitudinal research. Finkelhor (1984) noted that much of the research that points to an intergenerational cycle has been done on convicted offenders, perhaps not a representative sample. The abused abuser may be most clearly seen in the later presence of pedophilia rather than other sex offenses (Freund & Kuban, 1994). Clinical experience, however, shows that many offenders do not disclose, or even explore, the possibility of victimization until well into the treatment process. This may actually result in an underestimate of the number of offenders who had been abused.

Sexual abuse has one specific but complex effect on many victims: sexualization. *Sexualization* refers to a developmental anomaly created by inappropriate exposure to sexual contact. Although it could be rooted in unusual exposure to sexually explicit media or adult-adult sexual behavior, it is likely to occur as a result of sexual abuse. This experience results in an artificial acceleration of psychosexual development. For example, the victimized 11-year-old shows the flirting and dating behavior of a 16-year-old while, of course, retaining the cognitive, physical, and social development of an 11-year-old. The sexualized child is clearly at risk for sexual behavior, early pregnancy, and sexually transmitted diseases.

## Other Effects

The impact of physical and sexual abuse is not easily quantifiable but is clearly seen in school and clinical settings and supported by the clinical experience of counselors and others. Some effects are

- the loss of trust, security, and the essence of childhood;
- ambivalence and conflict of feelings—love and hate, rage and guilt, stoicism and fear;

- the creation of defenses: walls of denial; repression and dissociation; the armor of anorgasmia, anorexia, and obesity; the weapons of the fist, the tongue, and the belt; the retreat to the bottle, the pill, and depression; escape from the family, society, and reality; and
- death, frequently invisible, unnoticed, unmourned, by overt or covert suicide.

These effects are far less clear than the checklists or red-flag guidelines that are supposed to describe symptoms of abuse. The frustration is that we don't/can't/won't deal with abuse until these time-bomb symptoms explode, and even then we do not link these with abuse unless we ask the right questions of the adolescent or adult sitting in front of us. As with underreporting, we probably underestimate the damage of abuse to the child and the child within the adult.

Damage to the family is less often noted or documented. The strained dysfunctional marriage or relationship is both a cause and effect of abuse, with the reported incident frequently acting as the crisis precipitant of divorce, separation, or abandonment. The nonoffending spouse, if there is one, becomes torn by guilt, fear, and anger, forced into the divided loyalty of spouse and mother, like the TV juggler with the apple, bowling ball, and chain saw. The siblings of the victim (if they are not yet victims themselves) not only are fearful for themselves but also defend against this by blaming the victim; for if the victim "deserved it" or "asked for it," then the offender can still be loved and trusted. Even extended family members are drawn into the fray, sometimes as supporters, sometimes as blamers, sometimes reliving their own guilt as past abusers.

The damage to society is detailed throughout the other chapters of this book—for as abuse affects the child, it becomes a (or the) major contributor to problems that include suicide, self-esteem, sexual acting out (and related problems of pregnancy and sexually transmitted diseases), eating disorders, and runaway behavior. Societal costs are economic (protection, prosecution, punishment), productive (loss of earning potential, long-term costs of disability), and structural as its familial foundation crumbles.

## The Youthful Offender

One clear and yet misunderstood effect of abuse is the young sexual "offender." The emergence of this issue in the professional literature was reviewed by Okami (1992). This is a category that includes adolescents who rape, intrafamilial sexual contact between an adolescent and prepubertal child, and contact between very young children that involves coercion or force. Clearly, this is a topic of interest for those working with at-risk youth.

The issue of sexualization leads to the discussion of the offender-as-victim-as-offender. Although exact numbers are hard to determine, clearly a majority of youthful offenders have been victims themselves although, perhaps, untreated. The effect of sexualization is the biggest factor here, but the dynamics of the victim of abuse are similar to those of the offender in this age group: isolation, alienation, and lack of intimacy. The sexualization acts as the magnifying glass, focusing these dynamics into a pedosexual contact.

How does victimization turn into offending? Certain clinical observations may provide helpful information (Higgs, Canavan, & Meyer, 1992; Rencken, 1989). The pedosexual behavior is likely to be limited to genital touching, although there may be other sexual behaviors such as exhibitionism or voyeurism. The victim is likely to be prepubertal and known to the offender, whether intra- or extrafamilial. The young offender is likely to have a history of physical or emotional abuse in addition to sexual victimization. This may reflect a generally chaotic family structure, sometimes held together by rigid rules and expectations. The offender may be rather compliant, withdrawn, and isolated from peers. Asocial behavior is more likely than antisocial behavior. There may well be gender identity or sexual preference confusion. There may also be a generalized preference for nonsexual contact with younger children.

We are struck by a picture of low self-esteem and inadequacy in the young offender, particularly in dealing with peers. There is also a probability of school adjustment difficulties. Obviously, if there has been sexual victimization, most of these noted patterns could be exaggerated. The youthful offender clearly has unique concerns. Much more clinical experience and research are needed in order to address these concerns.

## CAUSAL FACTORS

Everybody asks "Why?" The victim, the offender, the family, the teacher, the physician, the judge, the taxpayer, and persons who are going to be abusers themselves for the first time *today* all ask "Why?" It would be wonderful if abuse could be discussed in terms of a misplaced gene or a hormone run amok or a mysterious tumor. It can't and it doesn't go away. The more we explore, the more we find patterns (not profiles), clouds (not clarity), questions (not answers), and rather reasonable-appearing individuals and families (not deranged sociopaths and perverts). There are no definitive answers.

### Physical Abuse

We live in a society that not only tolerates but also condones the hitting of children. We teach spanking of children in order to break their will (Dobson, 1970), use corporal punishment in our schools, the societal institution that is supposed to model relationships with children (Maurer, 1972–1994), and generally devalue children and childhood (Elkind, 1987). We are also a society that values violence and advocates violent solutions to problems (TV Guide, any week). Obviously, we should not be surprised that physical abuse exists. But we are surprised!

Physical abuse may come from either parent and may be directed at one or more children, frequently in a repeated pattern, and is typically accompanied by abusive language and humiliating punishment that may not be physical (Justice & Justice, 1976).

The dynamics of the physically abusive family were reviewed by Justice and Justice (1976), who integrated seven models—psychodynamic, personality or character trait, social learning, family structure, environmental stress, social-psychological, and mental illness—into an eighth model they termed *psychosocial systems*. This goes beyond the family system to include components of the other models, from internal to external influences. The abusive family is seen as having difficulty coping with changes and shifts that occur in systems, particularly those labeled as *life crises*. The family is frequently isolative, with poor support, and enmeshed—that is, fused within itself into a rigid system. Such families are then unable to handle children's behavior problems, particularly in combination with other stresses.

These dynamics produce what Bowen (1966) described as undifferentiated individuals. These undifferentiated adolescents are those that we consider to be at greatest risk and likely to repeat the cycle of abuse as well as the other behavioral effects noted earlier.

## Sexual Abuse

A similar set of dynamics also applies to intrafamilial sexual abuse. These families are seen as isolative, rigid, and conservative/traditional in their style (Finkelhor, 1979; Herman, 1981). They tend to devalue or discount communication and depend on clear power structures. They are not cohesive and adaptable (Alexander & Lupfer, 1987). Sexual functioning is also likely to be poorer (Pawlak, Boulet, & Bradford, 1991) as are coping strategies used in stress situations (Neidigh & Tomiko, 1991).

There are some patterns, of course, that are specific to sexual abuse and more complex. The research and clinical experience in this area are more recent and hampered by societal bias and language/jargon confusion. Although much of society condones some hitting of children, there is universal contempt for any sexual contact with children (even sexual abusers detest other sexual abusers). It is interesting that the roots of this contempt may well have more to do with our societal negativity toward sex than with our desire to protect children.

Like other stereotyping processes, language reflects society's negativity. Terms like *molester, pervert, deviant*, and others even more hostile prevent us from understanding and solving the sexual abuse problem. This chapter uses the term *pedosexual* to refer to "any sexual contact involving a child without judgment or diagnostic/prognostic implications" (Rencken, 1989).

Pedosexual behavior is a heterogeneous grouping with different family and psychodynamic issues. In this chapter, the focus in on intrafamilial sexual abuse because it is the most common form, but youth may also be victims of

- pedophilic contact, where the offender has a compulsive arousal pattern to prepubertal children;
- rape, where physical trauma and violence may inflict additional problems;
- addictive sexual behavior, where the child may become an outlet of opportunity; and
- extrafamilial contact, where the offender may or may not be previously known to the child. (Rencken, 1989)

Intrafamilial sexual abuse may have rather differing systemic patterns. These patterns represent different ways in which the role boundary that divides adults and children in a healthy family is violated. That boundary may be violated by a dictatorial father, who sees spouse and children, equally, as possessions for his sexual gratification; an immature/dependent/irresponsible father, who becomes like one of the children by exhibiting irresponsible work, relationship, or substance abuse behavior; and a pseudoadult child, who is encouraged to become a substitute mother/spouse.

Societal dynamics are also important in sexual victimization because it is clearly an offense committed by men against (mostly) women. Even when men are victims, there is still the concept of sexual objectification, the use of those less powerful for sexual gratification (Finkelhor, 1984; Russell, 1986).

## Conclusions

Both physical and sexual abuse create current and future problems for the child that may be related in intensity to the amount of coercion and conflict involved. Finkelhor (1984) emphasized the impact of coercion on the future adjustment of sexual abuse victims, noting that the prognosis seemed better, for example, for children who were verbally seduced as compared to those who were physically intimidated or threatened with weapons. The coercion factor applies similarly to physical abuse victims.

What is less clear is the component of emotional conflict. Clinical experience has shown the tremendous energy behind the love-hate dilemma of abuse victims. Children in both physically and sexually abusive families retain affection for each parent even while fear and anger stir beneath the surface. It seems that the greater this love-hate conflict, the more difficulty the child has in resolving abuse issues. This conflict may be felt more often in sexual abuse situations in which the behavior may seem less hurtful or painful to the child, thus increasing the probability that the child feels guilty about enjoying the abuse. In both types of abuse, the child may also feel that he or she "deserved it," again increasing the guilt and confusing responsibility issues.

Why does one family create physical abuse whereas another creates sexual abuse? Or both? The answer is not clear. There is no clear profile for offender, nonoffending spouse, or children in either abuse situation. What does seem to be common between the two are consistent issues of control and power. In either situation, the parents are likely to feel a significant lack of effective power and control. They attempt to gain, or regain, some of that power and control through dominating the children, which not only results in a transient feeling of power but also feelings of guilt that perpetuate the original feelings of powerlessness and loss of control. On the contrary, but to a lesser extent, the children in both situations may be imbued with a false sense of power that actually increases their vulnerability.

With both power and control as central issues, it may well be that sexual abuse is differentiated by the sexual nature of the behavior. This sexual component may or may not include specific sexual arousal to children, but it does include the previously mentioned objectification. This sexual component may be added to the basic power and control issues through previous victimization, societal sex negativity, problems with intimacy or sexual dysfunction, or a combination of conditioning factors.

## APPROACHES TO INTERVENTION

Interventions may be either therapeutic or preventive, with considerable overlap between the two. In fact, it could be said that many therapeutic or treatment approaches are really preventive in that they serve to prevent the child from being victimized again, the offender from perpetrating again, and the cycle of abuse from perpetuating. This section presents therapeutic interventions (immediate and delayed, clarification of roles and responsibilities, empowerment, group methods); the following section describes prevention strategies.

Typical intervention approaches in the physical and sexual abuse areas have been family based. This is particularly true as counselors work with at-risk youth. The specific intervention strategy is, of course, going to depend on the situation. Counselors know, however, that family dynamics issues, as noted earlier, have a big impact on their work. Regardless of the specific strategy—individual, family, or group; therapeutic or educational—family issues need to be addressed.

Intervention strategies involving the victim of physical and/or sexual abuse are similar enough to be grouped together in a chronological sequence for this discussion. Exceptions are noted. Within this broad strategic approach, many specific techniques may be utilized, and counselors may well find themselves utilizing several different techniques, approaches, and modalities on any given case.

Therapeutic models include play therapy (Long, 1986; Oaklander, 1978; Sgroi, 1982); mother-child bonding (Damon & Waterman, 1986; Giaretto, 1982); family systems therapy (Friedman, 1988; Gelinas, 1988; Giaretto, 1982);

and group therapy (Blick & Porter, 1982; Delson & Clark, 1981; Justice & Justice, 1976; Porter, Blick, & Sgroi, 1982). Educational models were reviewed by Goldstein et al. (1985) to include control and interpersonal skills and improved parenting. The strategies described include components of all these approaches.

In order to be implemented effectively, any approach should include some clear, underlying philosophical assumptions (Rencken, 1989). These assumptions are necessary because both physical and sexual abuse test the limits of our ability to be objective, empathic, and nonjudgmental.

These assumptions include the following:

- The problem is treatable. The victim becomes the survivor.
- The victim carries no responsibility for the abuse but can assume responsibility for recovery.
- Acceptance of feelings and provision of support are consistently necessary.

## Immediate Intervention Strategies

Intervention strategies are either immediate or delayed, the latter occurring 1 year or more after the last abusive contact. Individual case situations clearly determine specific strategies, but experience has shown the need for different approaches for these time frames. Counselors may, of course, become part of (or withdraw from) the intervention process at various points.

The counselor may be one of the first adults to hear of the abuse and has two tasks: report the abuse and support the victim. The child should be told that a report will be made, and as the discussion of the abuse progresses, support of the child takes precedence over interrogation. The tendency to press for details may be neither helpful nor necessary, with a focus on reassuring the child of having done the right thing and accepting the child's feelings of fear, anger, guilt, ambivalence, and confusion. This support should be done without unduly predictive statements from the counselor, such as "Everything will be better," or "Don't worry, he'll be going to jail," or "You'll be going home soon," any of which may not turn out to be accurate.

Although specific feelings may be somewhat different in physical versus sexual abuse situations, there may be even more variation from one individual to another. Whereas physical abuse may primarily trigger fear and anger/rage reactions, sexual abuse additionally includes an increased probability of guilt. The sexual abuse victim seems to have wider swings from fear to rage to guilt. The latter is the most difficult for many adults to understand. The affectional bond between parent and child remains more intact than we anticipate, compounded by the child's natural egocentricity, which results in the perception that the cause of the family's problems is the report rather than the abuse.

The guilt and ambivalence a victim experiences are so strong that the counselor should assume that there is a suicide risk in every case and monitor that possibility during crisis times. The critical phrase here sounds something like, "They'd be better off without me," or " I'm the cause of all the family's problems." The suicide risk is particularly high in adolescents, but all members of the family should be considered to be at risk.

The key to dealing with this fear, rage, and guilt, particularly during the crisis stage, is a focus on the child. All these feelings are "OK for kids" and totally acceptable. The children can have an appropriate sense of relative powerlessness in order to emphasize their lack of blame and fault. They can retain this developmental role of child and still build appropriate power. At this point, the permission to feel is critical.

The counselor can be an advocate for, and supporter of, the child without offender-bashing. Counselors risk involving their own biases of anger and disgust toward the child abuser, which only adds to the child's confusion. Instead of being in an adversarial relationship with the offender(s) and the rest of the family, the counselor can begin the process of systemic intervention here in the crisis phase. It may not always be possible to make such an intervention (e.g., if the parents deny the abuse). If such is the case, the child clearly needs the primary support of the counselor.

## Clarification of Roles and Responsibilities

The second stage of intervention requires more emphasis on the family system. The systems approach acknowledges that the whole family, with all its internal and external influences, has set up the structure and dysfunction that led to the abuse, either physical or sexual. The systemic framework can be helpful even if the counselor has access only to the child.

As noted previously, the issues of dysfunctional role boundaries, inappropriate division of power, and gender role stereotypes are all a part of the destructive family system. The family as a whole has a responsibility that enables the counselor to enlist the whole family in mutual empowerment and responsibility for changing the maladaptive behavior, a very powerful, positive force. Although accepting this responsibility is difficult for many families and resistance to treatment is typical in this phase, it is a part of the return of the child to an appropriate role in the family. This role includes expressing feelings, receiving nurturance and protection, and taking an age-appropriate share of responsibility.

One of the best tools for accomplishing empowerment in this stage is a series of apology sessions—of structured confrontations between the victim and abuser. Sessions are similar whether or not the family is together or whether it will never be reunifying. The first of these sessions should take place as soon as the child is ready, with the bulk of them scattered through the middle stages of treatment.

The child must have a good sense of being protected before attempting a direct or indirect confrontation. This includes having discussed details of the abuse with his or her counselor and having acknowledged (probably not yet resolved) the feelings. The child should have a sense of having a support system whether or not he or she really wants the confrontation. Both child and abuser should be specifically prepared for the session by role-play or similar techniques. The abuser should be encouraged to apologize for the specific behavior of the abuse as well as its setup. Responsibility issues should be clarified, and the report to authorities should be affirmed as a positive and necessary action. The child's responses, although frequently not predictable, should nevertheless be reaffirmed as OK. Further apology sessions should focus more on details of the abuse, patterns that set it up (including substance abuse and communication issues), and the family secret dynamics.

There are many cases, of course, where this direct confrontation is not possible. The same basic goals apply in an indirect confrontation: expressing feelings, clarifying responsibilities, and creating protection. Strategies can include role-play (with counselor, with dolls, with other counselors in the support team), Gestalt techniques (empty chair, pillow, doll burial symbolism), writing or dictating letters (or drawing pictures), which may or may not be sent to the abuser, or other expressive play (clay, paints, sand). These confrontations, even if indirect, should still be structured, with clear closure points.

## Empowerment

An important focus of treatment is empowerment. This focus is not necessarily time-defined but is, rather, a sequence of tasks that proceeds through the whole treatment process. A basic sequence of empowerment (Rencken, 1989) is

- reinforcement of the report;
- rebonding with the nonabusing parent;
- assertiveness and self-protection;
- redefining the relationship with the abuser;
- resumption of age-appropriate roles whenever possible; and
- positive control and attitudes regarding violence (physical abuse) or sexuality (sexual abuse).

The imbalance of power is one of the key elements in setting up both physical and sexual abuse. The child is powerless against the physical, verbal, and affectional power tools of the adult. Children may show this powerlessness in seemingly contradictory behaviors, with one child becoming withdrawn, isolated, and helpless, and another acting out sexually or aggressively and rebelling at school.

Regardless of the behavior, the roots are the same: powerlessness and anxiety. These effects may be doubly traumatic when we consider that in many families these children are given unusually powerful, responsible, pseudoadult roles before the abuse.

After the abuse, the child may use inappropriate power techniques to regain the perceived loss of power. Parents can try to deal with this through typical techniques such as limit setting and explaining consequences. They also, however, can use positive approaches to empower the child, reducing the child's need for unproductive power. The first time for emphasizing this positive power is at the time of the report.

The report can, of course, be a scary time because it is a powerful "weapon" for protection. The child needs strong reinforcement that the report is a reasonable and appropriate process, and that now adults will be responsible for his or her protection.

The nonabusing spouse will, it is hoped, be the most important "protector" of the child; therefore, this relationship needs a special focus in order to accomplish "rebonding." This dyad should receive special focus in treatment and visitation, continuing to meet as a dyad at various times throughout the treatment process.

One of the most difficult goals of empowerment is obtaining a balance between assertiveness and self-protection on the one hand and aggressiveness and dictatorial power on the other. The child does have the capability for self-protection and the right to privacy of his or her body, including the right to "say no" while maintaining the child role in the family. The basic message is similar to what we would give to an adult: "Taking care of myself does not infringe on the rights of others or relieve me of social or familial responsibilities." This focus on assertiveness is facilitated greatly through peer group work.

It seems obvious that the child's relationship with the offender must be redefined. Many members of society would redefine the relationship by separating the two, by either incarcerating the offender or removing the child. There are other options. Through the combination of individual, dyad, triad, and group treatment as well as carefully monitored visitation, a major shift can occur in that relationship.

One frequent question professionals and others ask is how the victim (or any of those involved) can possibly "forgive and forget." The truth is that they don't. They probably shouldn't! One analogy that may be helpful is that the abuse, like other traumatic events, is eventually "filed away." That is, abusive incidents certainly continue to exist as memories but, with time and effort, are removed from daily routines. There may be times, of course, when the files are pulled back out so that some issues can be handled. This filing analogy allows victims and families to get on with their lives while still acknowledging the reality and responsibility involved, rather than using denial and minimization that exemplify the pathology.

The last task in the empowerment process is a reinforcement of positive control. For the physically abused child, this includes information and modeling that demonstrate that problems can be resolved without violent physical means. For the sexually abused child, there is also the need for current and complete information about sexuality (despite possible parental resistance), including anatomy and physiology, sexual response, contraception, values, psychosexual development, relationships, and societal attitudes. The child also should receive strong messages about the need for consensuality and lack of harm, in contrast to his or her experiences, and the concept that being in positive control over self also includes a positive control over his or her sexuality. McCarthy (1992) noted that the term *victim* should not be used as a self-definition for survivors because it is perpetuating the powerlessness. Empowerment, then, includes the concepts of positive assertive control and responsibility as well as appropriate feelings of power.

## Group Methods

Group work can be an important part of a planned intervention as well as a prevention mechanism. Groups may be focused on self-help and mutual support, education, counseling/therapy, or a combination thereof. They may be oriented toward children (victims or siblings), parents, or whole families. Structured self-help groups such as Parents Anonymous for physical abuse and Parents United for sexual abuse provide national networks for support and education and may be a helpful resource.

Parent groups were described by Otto (1984) and Devoss and Newlon (1986). Damon and Waterman (1986) provided a highly structured parallel play group model in which mothers and children meet separately and together with an emphasis on bonding/rebonding.

## Delayed Intervention Strategies

The counselor working with at-risk youth, whether in the school, mental health program, or other settings, typically has the benefit of dealing with the abused child within a year of the last abusive incident. Because many children are abused in their preadolescent years and abuse is not reported, there are situations in which the counselor may be dealing with a delayed intervention even though the client is still only an adolescent. The strategies for delayed intervention are similar whether the client is male or female, adult or adolescent, with some individual variations.

The overriding issue in delayed intervention is that, to a greater or lesser degree, the child has built up defenses to cope with the abuse. Although these defenses may initially have been functional, they probably present significant obstacles to both identification and treatment of affective, relationship, and sexual issues. These defenses are also a part of the relatively recent controversy about recovered memories, with allegations that counselors or therapists are, perhaps unintentionally, planting ideas about abuse in the minds of clients (Wylie, 1993). Do we assume that all children have been abused? Not exactly!

For abused children, a general question about family functioning such as "How are things going at home?" may trigger anxiety and secretiveness. Even if this kind of question does not elicit strong reactions, the counselor can use general permission-giving statements such as "Lots of times kids tell me about scary (painful/unusual/inappropriate) things that have happened to them. Sometimes things have even happened a long time ago." A follow-up permission statement may be something like "Sometimes parents hit kids [pause] or yell at them a lot [pause] or touch them where it doesn't feel good [pause]. Kids talk to me about that kind of stuff." The permission statements should remain that and not turn into interrogation. Permission may allow discussion of abuse that has occurred without the actual planting of suggestion or implication.

If the victim/survivor acknowledges a history of abuse, the counselor may still have to exercise patience in allowing details to surface through consistent permission and encouragement, again without interrogation or suggestion: "You've told me about your father touching your breast. Sometimes remembering that gets you thinking about other things that happened."

Because of the strong defenses seen in delayed intervention, there is frequently a strong emotional conflict that has been repressed. As noted earlier, this conflict (affection vs. rage, love vs. hate, pleasure vs. disgust, guilt vs. anger, fear vs. intimacy) is a major treatment issue and should receive extra attention from the counselor. The client may be resistant to exploring this conflict.

That same repression and resistance may also apply to feelings in general. Affective awareness may be an important goal, particularly if there is indication of dissociative behavior. Clients may report an inability to feel pleasure or anger. One of the tragic ironies in these cases is, for example, the young woman who engages in sexual behavior often but is not orgasmic. Counselors may find themselves spending considerable time and effort exploring feelings that may or may not seem relevant to the abuse.

Clients, particularly adolescents, may express strong reservations regarding the possibility of reconciliation or reunification. They can be reassured regarding their safety and need for protection. They can also be encouraged to use the counseling process for their own psychological confrontation and reconciliation (see the discussion of apology sessions). They can be given the option of bringing out the unresolved issues, dealing with them, and then filing them away, all with the emphasis that they have control over the process and, in fact, their life.

One final strategy in delayed intervention is the use of group structures, both support groups and therapy groups. Although groups may generally be valuable treatment modalities for both victims and abusers, they are particularly valuable in delayed intervention. Mutual support, especially during psychological confrontation, is critical, as is reinforcement for affective awareness and empowerment. Self-help groups such as Parents Anonymous and Parents United may again be helpful.

## APPROACHES TO PREVENTION

With the emphasis on prevention that is a focus of this book, the message is clear that prevention of all these risks is both essential and complex. That message is magnified when it comes to body violation, particularly sexual abuse. Prevention programs, typically based in schools, are susceptible to considerable criticism (Berrick & Gilbert, 1991; Rencken, 1989; Tharinger et al., 1988) and, probably, reflect society's wishes that we would just as soon not pay attention to this problem. Body violation takes second place only to HIV prevention in the theoretical hope that if we just close our eyes tight enough, it will go away!

School and community prevention programs, sometimes called *safety curricula* (partially to avoid using the dreaded word sex) typically focus on identification of abuse (signs, symptoms, and reporting), body ownership, trust issues, and saying "no" (the latter three sometimes grouped under the term *empowerment*) (Tennant, 1988; Tharinger et al., 1988). Curricula that are aimed at children frequently use books in conjunction with movies, puppet play, drawing/coloring pages, or behavioral role-playing. Typical messages include

- the right to safety of the child's own body and nobody else's right to touch it;
- saying "no" to unwanted or uncomfortable touches;
- assertiveness;
- good versus bad secrets; and
- reporting abuse. (Rencken, 1989, p. 166)

Certainly, these messages are reasonable for both physical and sexual abuse prevention, but they are highly subjective, complex, and developmentally difficult for children to understand. Tharinger et al. (1988) made two empirical and two philosophical objections to existing programs. The two empirical concerns were that there is no evidence that children understand the concepts that are being stressed (good touch/bad touch, private parts) and that even if they do get it, there is not any evidence of enduring effect. It is, in fact, almost impossible to prove any reduction in abuse due to school prevention programs beyond an increase in reporting (Berrick & Gilbert, 1991).

The philosophical concerns (Tharinger et al., 1988) included the provocative question, "How can we teach about sexual abuse without dealing with sex?" (as well as the parallel question concerning how to teach about physical abuse without talking about violence in our society). The prevention programs are forced to use euphemisms like *private parts* and focus on sex-negative messages, neither of which is reasonable. Indeed, basic sexuality education, including appropriate naming of body parts, has been shown to be an effective part of sexual abuse prevention (Wurtele, 1993). Indeed, talking about sex abuse without knowledge of sex is "like discussing 'quacking' without being able to talk about ducks" (Rencken, 1989).

The other philosophical question is whether we are placing the responsibility for protection and prevention on the shoulders of the potential victims of physical and sexual abuse. This is particularly true with the current misplaced emphasis on "stranger danger," which incorrectly paints a picture of evil men in raincoats, rather than on the true dangers from within the family. Some critics point out the unfairness, ineffectiveness, and negative effects of placing that burden (Conte, Rosen, & Saperstein, 1986; Crewdson, 1988; Krazier, 1986) and suggest that the burden should be shared more equally by the adult society.

So far approaches to prevention have been less than ideally successful. A more effective approach may be to implement three axes for sexual abuse prevention that apply almost equally to physical abuse: empowerment, sex education, and gender equity.

The first axis involves real empowerment. This part of the current prevention programs makes sense but needs to be broadened and strengthened. Assertiveness and the ability to say "no" are important, but they can only work if there is a sound foundation of self-esteem, responsibility, and age-appropriate control. Counselors know how to work on these skills. We must do it.

Sex education, the second axis, applies more specifically to sexual abuse but has clear benefit in a range of prevention activities. Despite myths to the contrary, we have almost no sex education in most of this country. We remain sexually illiterate as children and adults and focus on the sex-negative attitudes that are fostered by this ignorance. Both perpetrators and victims are created by this void. Krivacska (1990, 1991) has articulated this need, noting that "...sexual abuse prevention cannot take place devoid of any sexuality education." Clear guidelines are available for this purpose (Sexuality Information and Education Council of the United States [SIECUS], 1991). It is essential to advocate for knowledge.

The third axis—gender equity—is rarely mentioned but is critical to the prevention issue. Both physical and sexual abuse are crimes of power and control, and in our society power and control are frequently based in gender role differences between males and females. Children and adolescents need to learn by our modeling that relationships are based on equitable power arrangements and agreements and not on might makes right.

We can improve our efforts for prevention without having to fight all the windmills of our society. Counselors in the school and community face a rewarding opportunity for really making a difference by preventing even one more victim.

## THE CHALLENGE

This chapter has sought to clarify the difficulty of dealing with physical and sexual abuse. Whether the intervention is immediate or delayed, abuse issues are complex, heterogeneous, and volatile. They require unusual sensitivity, flexibility, and objectivity on the part of the counselor.

The counselor may fill several, sometimes overlapping, roles in dealing with abuse: primary counselor, support team member, advocate, or prevention specialist. All are valuable.

The school or mental health counselor needs to be able to deal with a team approach, with its attendant frustrations and logistical difficulties, especially because some individuals and agencies may not be therapeutically oriented.

The counselor should be particularly cautious about recognizing his or her limitations in this area. Even the experienced specialist in the field frequently refers individuals or families in order to maximize the counseling relationship and goals.

The effects of physical and sexual abuse are so pervasive that their presence should be assumed in the majority of adolescent problems until they are definitely ruled out. This can be done routinely, without negative impact on the counseling relationship.

Despite the difficulties, dealing with the abused (and the abuser) presents an important and potentially rewarding challenge. Changes are frequently dramatic and lasting, with many families not only improving from their earlier dysfunction but also actually becoming healthier than average untreated families.

In physical and sexual abuse, all treatment is truly prevention. As counselors, we have the unique combination of philosophical base and clinical skill to make a major impact on this problem—if we open our eyes, ears, and hearts.

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# 5 Who Cares What I Think: Problems of Low Self-Esteem

*Sandra S. Meggert*

We observe many adolescents in pain. We see many with negative attitudes or low self-esteem and suspect there are many more. Many researchers believe that one of the major causes of deviant or potentially destructive behavior is low self-esteem (Kaplan, 1975; Leung & Drasgow, 1986; Yanish & Battle, 1985). A review of the literature supports the belief that negative self-esteem affects behavior in negative or destructive ways (Aronson & Mettee, 1968; Graf, 1971; Kaplan, 1975; Kaplan, Martin, & Johnson 1986; Lorr & Wunderlich, 1986; Yanish & Battle, 1985). Kaplan (1976) stated that poor self-esteem or "negative self-attitudes increase the probability of later adoption of each of a range of different types of deviant responses" (p. 788). Low self-esteem is a critical factor in at-risk behavior. Eskilson, Wiley, Meuhlbauer, and Dodder (1986) reported that adolescents who feel excessive demands to succeed academically are apt to disclose involvement in deviant activities, to have low self-esteem, and to feel inadequate and unable to fulfill their families' aspirations for them. Aronson and Mettee (1968) used college students as subjects in a study of dishonesty. They hypothesized that students with "low self-esteem are more likely to engage in immoral behavior" (p. 74). Results showed that 87% of the subjects with induced low self-esteem cheated on a test as compared to 60% of the neutral group and 40% of the induced high self-esteem group. In a similar study, Graf (1971) reported that 40% of those with induced low self-esteem, 17% of the neutral group, and 14% of the group with induced high self-esteem engaged in dishonest behavior.

Kaplan's (1976) theory suggests that low self-esteem influences a person to adopt delinquent or other behaviors that are deviant from the norm. The theory identifies two routes that negative self-attitudes may take to influence deviant behavior. One is that these attitudes make conformity to membership group patterns painful or distressing; the other is "by influencing the person's need to seek alternatives to the disvalued normative patterns in order to satisfy the self-esteem motive" (p. 788).

The results of a study of adolescents at risk for compulsive overeating (Marston, Jacobs, Singer, Widaman, & Little, 1988) showed that students designated at risk perceived their life quality as poor, and the authors hypothesized that this meant they are getting along poorly with the person to whom they feel closest. Because esteem is closely tied to perceived evaluations from significant others, the quality of significant relationships is a crucial ingredient of self-esteem. The research findings of Yanish and Battle (1985) supported the importance of significant others to the adolescent. They found depression in adolescents to be more strongly affected by the relationship with parents than with peers. A longitudinal study by Cohen, Burt, and Bjorck (1987) indicated that low self-esteem and depression, an indicator of low self-esteem, are positive predictors of controllable negative events, for example, expulsion from school.

Simmons, Burgeson, Carlton-Ford, and Blyth (1987) stated that young people who encounter several important life events at the same time they are adjusting to the changes of adolescence are expected to be at greater risk than those who have longer periods of time to adjust to adolescence. Findings in this study showed that girls suffer loss of self-esteem, and both boys and girls show declines in GPA and participation in extracurricular activities. For girls, each subsequent life change brings more difficulty with coping. The authors suggested that, in terms of self-esteem, this group of young adolescents does better if one aspect of their life is comfortable. If this is accomplished, then the timing and pacing of major changes are of primary importance.

As discussed in the many preceding examples, adolescents who exhibit signs of low self-esteem may be considered at risk for adopting or experimenting with deviant or potentially destructive behaviors. These young people may or may not be responding to life situations with deviant behaviors currently. However, when the signs indicate low self-esteem, interventions designed to improve self-esteem are important to help them avoid at-risk behaviors.

This chapter examines low self-esteem as one of the primary causes of the at-risk behaviors just described and delineates strategies and programs to prevent low levels of self-esteem. Self-esteem is defined in relation to at-risk youth and behavioral descriptions frequently linked to low self-esteem discussed. Causal factors that influence the development of self-esteem as well as prevention strategies that can be used by the individual, parents, schools, and communities to make young people feel valued and significant participants in making their environment a satisfying, safe, and rewarding place are presented. A case study describes a successful experimental program with at-risk students that has brought about changes that reflect improved levels of self-esteem.

## DEFINITIONS OF SELF-ESTEEM

*Self-esteem* refers to subjective evaluations of worth. These value judgments develop through personal success or failure experiences, interactions with others, maturation, heredity, and social learning, and are formulated from an individual's perspective. Kaplan (1975) discussed the self-esteem motive as being an individual's need to optimize positive feelings about self while reducing negative feelings. It is the process of increasing feelings of self-respect, approval, worth, and esteem. When the balance is on the negative side, a person is said to feel self-rejection, self-derogation, and, in many cases, self-hate.

Self-esteem is also a function of perceived evaluation by significant others. Mack and Ablon (1983) believed that no human is ever totally independent of the evaluation of others, and everyone retains "to some degree, a dependence upon connectedness with others for validation of our worth" (p. 10). A person's self-evaluation is referred to as self-esteem (Robison-Awana, Kehle, & Jenson, 1986). It is influenced by the individual's feelings of competence and efficacy. Two other terms are sometimes used interchangeably with self-esteem: *self-concept* and *self-acceptance*.

*Self-concept* refers to the perception individuals have about their personal attributes and the roles they fulfill. Some of these perceptions are accurate, and some are not. We receive feedback about the roles we play and internalize information about the character and quality of our role performance (Beane & Lipka, 1980). "Self-concept refers to the valuative assessment of those descriptions (p. 3)." For example, individuals have an academic self-concept, a social self-concept, or a physical appearance self-concept. Elliott (1988) maintained that anyone with low self-esteem has an unstable self-concept. The term *self-acceptance* pertains to the degree to which people are comfortable with their self-concept (Frey & Carlock, 1984).

For purposes of this discussion, *self-esteem* is defined as the pattern of beliefs an individual has about self-worth. It is the subjective part of self-concept, the evaluation of self and behaviors based on an individual's perceptions of personal experiences and feedback from significant others. It is expressed in feelings of power or helplessness, called *efficacy*, or in beliefs about personal control.

## INDICATORS OF LOW SELF-ESTEEM

Beliefs about self develop as a result of perceptions and evaluations of success and failure experiences. In this process, an individual forms some beliefs about personal control (internal vs. external) and personal effectiveness (self-efficacy).

*Locus of control* refers to a person's belief about outcomes. Locus of control is the conviction that success or failure at a task is internally determined by one's own actions or ability, or that the outcome is due to external influences such as luck, fate, or chance. According to Johnson (1981), "internal attributions for success are associated with higher levels of self-esteem," and low self-concept "was predicted independently and significantly by internal attribution for failure and external attribution for success" (p. 174). Abramson, Seligman, and Teasdale (1978) suggested that low-achieving students ascribe any failures to internal causes and all successes to external causes.

Personal effectiveness, or self-efficacy, as defined by Benoit and Mitchell (1987), has four essential elements: awareness of required behavior to bring about success, expectation that this behavior will be successful, belief that there is a relationship between behavior and outcome and that this behavior will have an impact, and belief that the outcome will provide something valued.

Evidence supports the fact that an individual with low self-esteem does most likely believe in luck (external control) rather than ability (internal control) to achieve success. However, failure is attributed to personal shortcomings (internal control). Because self-esteem judges whether such an individual can, in fact, succeed at a given task, the lack of belief in self makes it likely that someone with low self-esteem will also exhibit feelings of helplessness or powerlessness, in other words, low levels of self-efficacy. In this case, a possible defense might be to deny that the outcome of the behavior has any value, and to withdraw or drop out.

Individuals with low self-esteem often find it necessary to develop defenses. People who have low self-esteem hurt. To avoid this hurt there is a tendency either to shun experiences such people believe will bring additional pain or to change these experiences in some way. They erect barriers or defenses. At times the individual might be hostile, critical, or suspicious of others, or lack identification with others. Sometimes retreating defenses are exhibited when a person avoids coming to grips with problems or denies reality (Kaplan, 1975). A person might retreat into an "I don't care" stance or simply resist trying. It is too much of a risk for someone with feelings of poor self-worth to be exposed to additional hurt or situations in which failure is expected.

Persons with low self-esteem may be distractible, timid, shy, withdrawn, inhibited, anxious, and less academically able (Domino & Blumberg, 1987), and have a narrow range of interests. They are more likely to daydream and to want to find jobs where they have little or no supervision and where there are minimal amounts of competition. From their perspectives, an ideal situation is one in which they have no supervision because then no one can confirm their failure. Generally, they express the idea that they do not really want to get ahead in life. This could be because they will not place themselves in a position where they expect to fail. This too is a defense.

Individuals with low self-esteem have few coping strategies. They often feel a lack of control over life events. They do not feel connected and have few, if any, expectations of future success. They lack a sense of belonging. Possibly, dropping out is a defensive way of demonstrating some power, self-defeating though it may be.

Low self-esteem can cause emotional distress as well. Many individuals who question their worth are sad, lethargic, tense, anxious, and angry. Some of these feelings stem from concurrent feelings of helplessness and powerlessness. Physically they may exhibit sleeplessness, headaches, or nightmares.

Those who have low self-esteem are generally dissatisfied with themselves and their lives, contemptuous of self, and have low levels of self-respect. Typically, they are fearful of new experiences and have a poor physical appearance and a low energy level. Apologizing, criticizing others, showing an interest in material things, and bragging are all indicators of low self-esteem.

## CAUSAL FACTORS

Parental, social, psychological, physical, environmental, and cultural influences affect self-esteem. They all contribute to the development of self-esteem to the extent that each or all of these are valued or devalued by significant others who provide feedback. This feedback is both verbal and nonverbal, overt and covert, and dramatically affects how adolescents see themselves.

### Parental Influences on Self-Esteem

Frey and Carlock (1984) identified a representative list of "psychological pathogens" to self-esteem (pp. 25–31). Many of these are associated with parental influences. These pathogens may persist throughout life and, if so, may consistently keep self-esteem low unless someone or something intervenes. Among the pathogens they identify, and the problems that might arise when these are present during childhood, are the following:

1. *Expecting perfection.* Nobody has achieved this state yet, but many people try! Carrying a burden of always trying to be perfect out of childhood guarantees failure. Those who have learned to set idealistic or unrealistic goals for themselves are constantly frustrated, critical, and impatient with themselves and others, always trying harder and never quite feeling successful. Negative self-evaluations, which are formulated by the individual from perceptions of adult reactions, deeply affect his or her feelings about self. Unless a person learns to set realistic goals and acknowledge small steps on the way, self-esteem remains low because the person never feels adequate.
2. *Inconsistency and failure to set limits.* Though some people believe consistency is a myth, children often search for consistency and limits, apparently seeking the security that structure and predictability provide. When that is missing, the result is anger, insecurity, and hostility.
3. *Failure to give positive feedback.* Many parents and significant others assume that children know positive behavior is appreciated and only respond to negative or improper behavior. Being constantly reminded or punished when behavior is inappropriate, and seldom being appreciated when behavior is appropriate, create feelings of inadequacy and inferiority.
4. *Failure to listen.* Failing to listen to a child indicates a lack of respect and communicates that the child or what the child is trying to communicate

is not important. When this feeling is carried through childhood, it fosters additional feelings of inferiority and inadequacy that are sometimes expressed in anger or hostility.

5. *Rejection.* Consistent rejection critically impacts an individual's self-esteem. The rejected child's basic needs are not being met, in some cases deliberately. Death, divorce, severe illness, or ignoring the child can all be viewed as rejection by a child with the ensuing feelings of inadequacy, guilt, self-hate, or self-rejection.
6. *Being a maladjusted role model.* Children who model their behavior after an adult who is maladjusted often end up disliking themselves because of those behaviors. Their self-esteem is greatly diminished in such cases.
7. *Failure to help children adapt.* Societal and cultural values are being questioned more now than ever before. It is difficult for children to feel adequate in a society where values are shifting or unclear. It becomes even more difficult when children try to adapt to a different culture and values conflict.
8. *Forcing children into a pattern.* Sometimes parents try to fit children into certain behaviors or patterns that may restrict their unique development or be beyond their capacity. This is sometimes called *living vicariously* and creates frustration, feelings of worthlessness, and inadequacy in both parent and child.
9. *Allowing and supporting procrastination.* Believing that one does not have the self-discipline necessary to complete a task contributes to poor self-esteem. The longer the child procrastinates, the more the feelings of inadequacy and worthlessness multiply. Concurrently, there is a loss of self-respect.

Frey and Carlock (1984) listed several additional pathogens and observed that "one can be the recipient of several of these dynamics" (p. 31). Each of these, or a combination of several, is detrimental to a child's self-esteem.

Parents have significant impacts on the self-esteem of their children. Parental attitudes and behaviors have been shown to affect children (Buri & Kircher, 1993; Lord, Eccles, & McCarthy, 1994; Ohannesian, Lerner, Lerner, & Von Eye, 1994). The number of divorces and remarriages and the child's subsequent adjustment was the focus of a study that found some evidence of a "negative linear relationship" between these variables (Lord et al., 1994, p. 28). Buri and Dickinson (1994) reported that although parental authority was predictive of self-esteem, these behaviors were less important that overgeneralization, particularly in females. The authors described overgeneralization as the inclination for a person to view a failure as an indication of his or her general inadequacy.

A consequence of the dynamics just described is that young people today feel unimportant or even irrelevant in their families (Glenn & Nelson, 1989). Many believe that they are important only when they are doing what someone else wants them to do. The authors speculated that this is one impetus for early sexual involvement. Sex becomes a strategy to make the individuals involved believe themselves to be significant in the eyes of someone else. The irony is that if the female has a child she is automatically treated as an adult when, in fact, there are now two children.

The need to feel significant is also a powerful motivator to become a gang member. News stories report daily regarding the initiation rites to join a gang. Some young people want so badly to belong that they lose their lives during the entry process.

Note that many of the pathogens identified are behaviors found in extremely inexperienced parents who may use the child to satisfy personal needs not previously filled. The child will not feel valued, may be confused, and, most likely, will develop low self-esteem. The cycle will remain unbroken unless there is some type of intervention.

## Social Influences on Self-Esteem

A basic assumption in social psychology is that self-concepts are heavily influenced by social contexts (Bachman & O'Malley, 1986). Each of us has a long history of dependency during infancy and childhood during which we need to receive positive responses from adults. We are motivated to behave in ways that increase the likelihood of receiving these positive responses. As children we internalize adult standards in this manner, and we attempt to regulate our own behavior and react with positive or negative self-feelings at the perceived evaluations/reactions of significant adults (Kaplan, 1976).

Kaplan further noted that low self-esteem is thought to be caused by self-perceptions that either our behavior or our characteristics do not meet personal standards valued by the social system; by self-perceptions that significant others do not value us positively or perhaps even negatively; or that a person might not have developed "normatively acceptable coping mechanisms" that could protect one from the effect of "self-perceptions of failure or rejection by others" (p. 790). Someone with a history of being devalued is most likely to have low self-esteem. This can be said to evolve from two sources: an individual's history of negative self-evaluation and perception, and perceptions of highly valued others in the environment responding to the individual with less than positive attitudes (Kaplan, 1975). An individual is more likely to value the attitudes of those persons "who were associated with need gratification or deprivation" (p. 37).

Society imposes strong gender-based role behaviors that continue their impact on self-esteem long after adolescence. A recent study has demonstrated that masculine bias is still strong in America (Burnett, Anderson, & Heppner, 1995). Masculinity, defined as having high levels of traditional masculine behaviors (such as competitiveness, decisiveness, and independence) as opposed to feminine characteristics (such as focus on relationships and nurturing) has been shown to be "significantly correlated with self-esteem for both men and women, but individual femininity was not significantly related to self-esteem in either sex" (Burnett et al., 1995, p. 325).

Even though masculine behaviors are clearly valued in America, they are not generally characteristic of at-risk youth. If they are evident in some, they are not generally evident in socially acceptable ways. For example, aggressiveness and rebelliousness might substitute for independence and competitiveness. Enns (1992) stated that "there is some evidence that the socialization process is even more stringent for men than it is for women, and that boys and men experience higher costs for straying from traditional gender roles than do girls and women" (p. 11). There is the possibility that absence of masculine skills in boys, and to some extent girls, has the potential of contributing to low self-esteem. Bower (1993) reported that development of self-esteem in males and females is different due to societal pressures that dictate male and female role behaviors. Some research has also indicated that teenage girls have lower self-esteem than teenage boys (Dwyer, 1993). A recent *U.S. News & World Report* article (Saltzman, 1994) surveyed research regarding self-esteem of adolescent girls. After examining several research studies, the author concluded that social science has no conclusive answers and that parents have to assess and address the needs of their daughters individually.

Many of the social changes are high-risk changes. As young people are alienated from society and practice more violent methods to feel significant and powerful, many die or become incapacitated. Wars are fought on TV and children feel threatened. Technology has changed the world of work, and many parents or parental figures are unemployed. Divorce is common; homes are broken. Values are lost. Young people hear of people their own age dying from the variety of perils to which they are exposed. Many of them believe that they will live short lives. No one has prepared them for the choices they have to make.

## Psychological Influences on Self-Esteem

It is "questionable, indeed, whether human beings can deeply experience positive self-worth except as the result of a relationship" (Mack & Ablon, 1983, p. 9). Everyone knows two basic truths about the self. One is that the self is alone and private, and the other is "that one is a real self only to the extent that caring and reaching beyond the self continue" (Yankelovich, 1981, p. 240). Therefore, an important psychological determinant of self-esteem is the individual's feelings about the level of success within relationships.

The whole notion of connectedness or belonging to someone is central to development of self-esteem. Belonging to a family, a culture, a community, or a school provides a connection to aid in sustaining a sense of worth. Lacking such a feeling, a person is likely to feel not valued, or not of value, and retreat into a defensive posture to protect the self from the pain of feeling isolated, hopeless, worthless, and unconnected. "Virtually all maladaptive defensive patterns in childhood, adolescence, and adult life have as at least one major purpose, protection of the pain associated with lowered self-esteem" (Mack & Ablon, 1983, p. 38).

Television has become a psychological determinant of self-esteem (Glenn & Nelson, 1989). Young people receive messages about the society in which they live in a passive manner. They do not have to participate to learn. In the past, people learned about functioning in society while they were actively involved in living and working. The learning might be trial and error, role modeling, or direct teaching, but individuals were active. The authors referred to this as *on-the-job training* or OJT. Today, with the use of television, children's reality becomes distorted. Within a short time, they see problems solved through miracles, violence, various medications, sex, and drinking. According to Glenn and Nelson (1989), they learn the following:

1. In productive and desirable social interactions drinking or substance abuse is necessary.
2. Pain, fatigue, listlessness, and boredom are all dispelled through self-medication.
3. Indiscriminate or uninvolved sexual encounters are appropriate ways to communicate.
4. Problems can be resolved instantly through manipulation, violence, and breaking the law.
5. Deferred gratification, hard work, and personal initiative are unacceptable, and drinking and self-medication can help a person avoid these stresses. Any stressful situation can be alleviated by using specific products and/or services. (pp. 42–43)

These "truisms" are further complicated by parents who foster the belief that most material possessions can be obtained in ways other than hard work. So because things come easy, there is no respect for possessions and no positive messages about the purpose of life. It is easy to speculate that if no active role modeling or teaching of healthier, more productive attitudes dispute these claims, young people may feel alienated, angry, and confused. When they use these same behaviors that work on television to solve their problems, they get into trouble. The nonacceptance of their behaviors confirms their sense of worthlessness and insignificance. The only way they can feel any sense of worth is when they are with others who feel and think as they do.

## Physical Influences on Self-Esteem

Inherited physical characteristics, such as physique, appearance, and handicaps also may influence self-esteem. The physical attributes that an individual has inherited can affect others' perceptions and behavior. Others may respond negatively to an individual's handicapping condition or physical appearance, thus affecting that individual's self-esteem, even though the individual's initial self-perception may not have been negative.

Others' reactions are also influenced by maturational rates. Adults treat children differently at differing maturation levels. Early maturing children are quite often treated as adults and develop positive self-esteem. But those who mature later and continue to be treated as children tend to develop low self-esteem. Even when this latter group matures, they often maintain old self-perceptions and the corresponding low self-esteem. Maturation also affects mastery of developmental tasks. Social disapproval, maladjustment, and increased difficulty in mastering higher level developmental tasks are all possible results of delayed maturation (Frey & Carlock, 1984).

## Environmental Influences on Self-Esteem

It is difficult to define the effect environment plays in the development of low self-esteem. A person learns values and has needs satisfied within the environment through social interaction with significant others, and if needs are not met and the expression of beliefs and values meet with disapproval within the environment, self-esteem is likely to be damaged.

An additional aspect of environment has to do with the groups within the environment with which the person identifies. Each member of a group is evaluated by every other member. If the group is significant to an individual, these evaluations affect self-esteem. For example, if a person's perception is one of not being valued by the group, low self-esteem is probable. Esteem is related to one's rank in a group rather than rank of the group when compared to other groups (Rosenberg, 1965).

As the population has moved from country to city areas, the environment in which children had built-in networks and role models has diminished and, in many cases, been lost. In the past, grandparents, aunts, uncles, cousins, neighbors, and friends were available to help educate and advise young people, and that was a given. In the absence of such an array of support, young people have turned to their peers for guidance and approval. In doing so, they use peer norms, created out of lack of experience, for evaluating behavior rather than the collective experience and wisdom of a network of adult role models (Glenn & Nelson, 1989).

Parents have also suffered a loss of support. In most cases, the parents have no network of relatives nearby to assist in parenting, and they have to depend on themselves to make the right choices. And they have no experience being parents. Because both parents usually work, they parent part time. In single-parent families, even part-time parenting is shared with other stresses involved in survival. So now we have time factors as well as inexperienced parents as well as the challenges presented to children in today's world. It becomes easier to see why parents use the same stress reducers as their children.

### Cultural Influences on Self-Esteem

Self-esteem is also impacted by the extent of the individual's identity with a broader group, a cultural or national group. If the cultural or national group is not viewed as esteemed by other cultures/nations, those identifying with the cultures/nations may suffer low self-esteem. We see this occurring with minorities when they experience difficulty assimilating another culture's values.

Difficulties arise when minorities identify with their own culture, are accepted and develop positive feelings of worth within that culture, and then try to make it in another culture. This is particularly painful when the culture of origin does not appear to be valued in the new culture, and the beliefs and values of the two cultures are divergent.

In previous generations, young people had roles to play that confirmed their value as important contributors to the welfare of the family and community. This gave them a meaningful role in their community and ensured the transfer of cultural beliefs and values (Glenn & Nelson, 1989). Changes in society have provided more passive ways for values to be transmitted to the young; the roles that are depicted in the media often do not reflect appropriate cultural beliefs and values. In addition, many young people do not have multiple adult role models who can correct inappropriate perceptions of behaviors and beliefs illustrated in the media.

## APPROACHES TO PREVENTION

The pervasive distress and too frequent demise of our young people seems to be out of control. Jason et al. (1993) reported that in Chicago schools, "more than 40% of children do not graduate high school" (p. 69). They believe that the problems leading to dropout often begin in the elementary schools. It is clear that some interventions, some low self-esteem prevention strategies, must be integrated into every level of the community. In this section specific approaches for parents, individuals, schools, and communities are discussed. No one segment of the population is solely responsible for providing prevention. All groups should overlap, and building and maintaining high levels of self-esteem should become an integral part of the total community structure. Though parents are charged with the initial environment for the child, they too are part of a community and have need of resources from the community. A global approach that could be utilized by the entire community is described at the end of this section.

### Family

The environment in which a child is raised has a significant impact on the individual's self-esteem (Barber, Chadwick, & Orter, 1992; Blake & Slate, 1993;

Cerezo & Frias, 1994). Historically, children were born into an intact family, and that was the primary environment in which the child learned about being an adult. Today, families vary in structure. Households where both parents work outside the home are common. Single parenting, stepparenting, joint parenting, parenting by someone other than the biological parent, and homelessness have altered family structures and added to the pressures young people face as they grow into adulthood. Many who find themselves in parenting roles have no idea how to accomplish this and fall back on personal experience. They feel the loss of assistance and experience that an extended family provides, so they parent as they were parented, as best as they can remember. They may have low self-esteem as a result of their own childhood experiences and perpetuate their own feelings of worth in their children. Their own parental role models may not have had the wisdom of the extended family experience either, and lack of parenting skills continues from one generation to the next.

In terms of prevention, steps must be taken to teach parents how to parent. Recognizing and admitting the need to learn parenting is a primary step in the process of building self-esteem. Today's parents have access to parenting classes and special support groups to help them learn to work with their children. These groups are sponsored by school specialists as well as churches and agencies in the community. Joining a class or support group serves a dual purpose. The parents learn skills at the same time that they are increasing their network of support. Getting to know neighbors is another excellent way to extend their support network and can serve as a means to check perceptions of neighborhood situations.

Parents must understand their own needs for success, status, and control as these needs relate to their childrearing practices. They must be able to put these needs aside and respond to each child as a unique person and to recognize and accept the contributions their children make in the family. There may have to be conscious efforts made to include each child and to discover ways in which each child can successfully contribute to the well-being of the family. Taking out the garbage can become significant if a child understands that his or her contribution is important to the family. When a parent asks a child for assistance with a task or project, one that cannot be done alone, the child learns that his or her contribution is an integral part in the task completion. In this case, it is essential that the child understands his or her help is not gratuitous but essential. For example, if the family pet has a thorn in a paw, it is difficult for one person to hold the animal, examine or probe the paw, and extract the thorn. It is much easier if someone else holds the animal. Asking for the child's assistance, and pointing out that this task is difficult or impossible for one person to do alone, validates the value of the individual's contribution.

Another way to prevent low self-esteem is to allow children to do what they can do and not do it for them. Often adults, who can do it faster or better, become impatient and complete tasks for the children. This indicates a lack of respect for the child and gives negative messages about the child's abilities and worthwhileness. These negative messages are both overt and covert and have a powerful effect on self-esteem. Though it may be difficult, allowing a child to complete a task more slowly and in a different manner or to make a mistake brings greater opportunities for learning. Using the mistake as a teachable moment is of greater value than scolding, punishing, or doing it for them.

Spending time with the child, talking or playing, gives positive messages about the child's importance. Letting children know that they are valued is critical in building self-esteem. Ironically, this is often the most difficult prevention technique; it takes time and is the first date to be canceled when schedules get tight. During regularly scheduled time together, bonds are cemented, relationships are nurtured, and both parent and child feel important. In using this strategy, parents must listen carefully, suspend judgment, and be accepting of the child's point of view. Children will discuss serious topics if they believe what they say will be heard and valued. They also learn from the role modeling.

Many families hold regularly scheduled meetings to discuss family matters. These meetings are used to resolve conflicts, plan outings, make decisions about the household, test out new ideas, and involve the whole family in a variety of discussions. Again, these should not be canceled except with solid reasons. If meetings are canceled too often, their usefulness diminishes.

The interesting effect of using preventative measures is that the parents' or parental figures' self-esteem grows as well. When parent-child interactions are positive and productive, both participants feel valued.

## Individual

Self-esteem develops as a result of interaction with and feedback from others. It is doubtful whether an individual can build self-esteem in a vacuum. If the feedback is negative, either verbal or nonverbal, the individual internalizes negative feelings about self and has poor feelings of worth. If feedback is positive and the individual feels successful, self-esteem is enhanced. An individual who feels valued and worthwhile has high self-esteem and responds to others in a manner that communicates this level of self-esteem.

It is difficult, perhaps impossible, for someone suffering from low self-esteem to undertake a prevention program alone. Most of the feedback that builds or destroys self-esteem comes either directly or indirectly from others. An individual is influenced by role models and can be encouraged to learn skills and attitudes that will lead to success experiences. As self-esteem is raised, a person may seek out avenues that will bring more success.

Volunteering, learning to be assertive, learning to cope with anger and conflict constructively, attending workshops and special classes to learn life skills, and entering programs that are specifically designed for young people are all ways an individual can build self-esteem. In each of these possibilities, external guidance is often necessary for a person with low self-esteem.

## School

Because every child has the opportunity to attend school, this is an ideal place to continue the low self-esteem prevention programs. Hamachek (1995) noted that school performance and "self-attitudes" (i.e., self-esteem) are interactive. Johnson, Johnson, and Taylor (1993) reported higher levels of self-esteem achievement and cohesion in fifth graders who participated in cooperative learning environments. Strategies for improving school performance cannot be developed without attending to methods to "help students feel better about themselves" (p. 422). Educators have long been aware of the need for students to feel good about themselves and what they can do. Many schools have peer-tutoring or lower-grade-tutoring programs, peer helpers, and student aides. In such tutoring programs students are paired with students for teaching or coaching. The tutored students are either peers or, in many cases, younger students in elementary schools. Peer helper programs train selected young people in listening skills and have them talk with and listen to their peers. Student aides assist teachers and office staff. Some of these programs tend to exclude the high-risk populations.

Because schools are community institutions and have the most contact with children, and because many services were available to families, but delivery was fragmented and/or crisis oriented, the West Virginia Education Association and Appalachia Educational Laboratory (1993) surveyed the existing school/community partnerships in that state. In this survey process, the researchers gathered information about problems inherent in school-linked services and about additional school-linked service possibilities. With these data, the research team developed profiles for each of these social service programs and made recommendations for changes at the school, district, and policy-making levels.

*School and district level recommendations*

> - The responsibilities of schools should include serving as a focal point to connect families with health and social service providers.
> - The mission of the school should include health and social services provision.
> - Educational focus should be on prevention and early intervention.
> - Schools should provide training to staff to teach them to work effectively with health and social service problems of students.
> - Research and evaluation should be undertaken regularly to assess program success and recommend any needed improvements.
> - Districts should establish foundations whose funds would be used to develop programs to benefit children and families. Independent sources would donate these funds. (p. 36)

*Policy recommendations*

- Funding for programs for at-risk populations should be provided for in the budget, which would serve to standardize school-linked programs. These programs should be protected from budget cuts.
- Early intervention and prevention programs should be given priority.
- Operational procedures of schools and service providers should be examined and changed if these procedures interfere with effective delivery of services. (p. 37)

The recommendations reflect the belief that no one group or institution is totally responsible for bringing health and social services to those community members who need them. The philosophy is that the entire community must work as a team, with the school being the common link between service providers and families.

Jones and Watson (1990) studied high-risk students in higher education. Several of their findings can be considered for earlier educational experiences as well. Recommended prevention programs and strategies are to

- Market benefits of persistent, positive student behaviors.
- Provide career information beginning at an early age. Encourage goal identification.
- Use low achieving college students to tutor students K-12. This raises self-esteem of each participant.
- Encourage and market counseling services as part of the curriculum. Involve teachers in the referral process.
- Provide in-class programs designed to teach positive attitudes and skills that would include acceptance of others, e.g., high-risk students.
- Use peer advisers.
- Enlist school organizations to develop programs to assist fellow students.
- Provide educational programs to teach teachers how to teach. Provide opportunities for teachers to learn alternative teaching techniques and ways to empower students.
- Evaluate testing materials to see that needs of high-risk students are being assessed effectively.
- Develop orientation programs addressing the needs of high-risk populations.
- Acknowledge school personnel who work with high-risk students by reducing class loads.
- Develop methods to assure high-risk students an in-school support system.
- Using local businesses, provide opportunities for high-risk students to do visits, internships, or part-time work in the community. Many schools invite business people into the classroom to work with students.

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- Provide programs for teachers and school personnel to examine their attitudes toward minorities, women, and other high-risk populations. (pp. 85–88)

## Community

If we accept the philosophy that at-risk students and families and the school are all part of the total community, any of the just listed strategies can be offered throughout the community and sponsored by any business or agency. Specific programs located in a major metropolitan area that may be similar to programs available in other areas are as follows:

### *YMCA Teen Services (1994)*

- *County Youth Initiative* provides opportunities for leadership training, public speaking, project planning and delivery of community services, and employment.
- *Earth Service Corps* provides opportunities for environmental education and action, leadership development, and project planning and implementation.
- *The Manifesto Newspaper* provides an opportunity, through a youth-produced countywide newspaper, for teenagers to share their ideas and creativity with members of the community.
- *Y-Zone* provides a safe, alternative environment for youth to participate in activities and special events on a weekend night. This has expanded in adjacent communities to being available both weekend nights.
- *Youth Employment* sponsors a youth-run espresso cart at a local YMCA. The youth are hired and trained before they begin working this cart.

### *Central Area Youth Association (CAYA)(1992)*

- *TeenPATH (Teen Parent Assistance and Transitional Housing Program)* provides assistance to homeless or near-homeless teen parents under the age of 18. The program's goal is to provide assistance to teen parents in breaking out of the poverty cycle. Through TeenPATH, stable, safe housing is found. In return, the teen parent(s) are required to complete high school, get work training and/or employment, and be responsible parents.
- *Mentorship* assigns role models who offer companionship, guidance, and support and help empower participants to be free of gang and drug involvement.
- *STARS (Special Tutor for At-Risk Students)* provides one-on-one tutorial services to at-risk students in grades K-8. Tutors are available both in school and after school in churches, libraries, and community centers.
- *Sports Program* provides adult role models who focus on team work, mental health, physical health, and individual and group responsibilities.

- *4-H Challenge* teaches participants, particularly minority males, coping skills, communication skills, problem-solving skills, and decision-making skills.
- *Introduction to Challenge* places youth in support groups and introduces rules, concepts, and benefits of the Challenge program.
- *Boot Camp/National Guard* introduces youth to orderly, disciplined environments and provides opportunities for building self-esteem.
- *Job Power* allows youth to explore assets and liabilities in regard to employment.
- *Ropes Course* provides outdoor activities to help adult and youth participants learn and develop problem-solving, goal-setting, and communication skills while experiencing total commitment.
- *I'll Take Charge* provides opportunities for youth to take responsibility for their choices.
- *Self-Determined Projects* allow members to determine, with guidance, their own projects that might not be available otherwise.
- *Multimedia* teaches students techniques and technology involved in video production while exposing them to drama, music, and arts.
- *Job Readiness* helps youth create contacts without turn-downs, teaches them job interviewing skills, and brings the community together to help youth become productive, responsible members of society.
- *Elite Boxing* provides a meaningful outlet for physically aggressive youth in a positive, acceptable manner.
- BALANCE *(Beautiful, Ambitious Ladies Able to Negotiate with Commitment to Self-Esteem and Excellence)* provides weekly support groups for young women, through which substance abuse education and services are provided (CAYA, 1992).

### *STARS I and II*

- Two community-based programs for African American youth, STARS I and II, targeted at-risk youth aged 6 to 10 years and 11 to 17 years and their parents or guardians. In STARS I "sessions focused on cultural legacy, family communication, the role of the extended family, and decision making" (Dabrowski, Avery, Gyger, & Emshoff, 1993, p. 4). The program for the older children focused on drug education, assertiveness, resisting peer pressure, raising self-esteem, and family communication. Program outcomes showed improvement in all areas for both adults and the children.

Additional community programs include volunteer chore services; training to become volunteers; volunteer opportunities in social service agencies, churches, and community agencies; and community projects sponsored by individual clubs and organizations, for example, Junior Chamber of Commerce and Boys and Girls Clubs. Many of these offer training and provide built-in support and networking sources.

## A Global Approach to Prevention

Seven tools that are critical to the parenting process and building of self-esteem have been identified by Glenn and Nelson (1989). These tools can also be used in schools, in the community, and by individuals. The authors noted that they discovered these tools, which are basic to survival in times of change, while they were studying failure, not success (p. 48).

*The Significant Seven*

1. Perceptions of personal capabilities
2. Perceptions of personal significance
3. Perceptions of personal power or influence over life
4. Intrapersonal skills
5. Interpersonal skills
6. Systemic skills
7. Judgmental skills (pp. 48–49)

Perception, as described by the authors, is "the conclusion we reach after we have had time to reflect on that experience" (p. 51). Perception guides our attitudes and behaviors, and as we mature, we become more and more creatures of perception. Perceptions include four components: the experience, what we interpret as significant about the experience, why it is important, and how we generalize the experience (p. 55). Because perceptions change as we mature and because they are unique to each individual, it is important that the four components reflect the perceiver's point of view. Even if an experience is shared, perceptions of the experience differ for each participant. It is significant to each person in different ways and important to each person for different reasons, and the experience is generalized individually. In terms of building self-esteem, the learner must see the personal importance and value of an experience for himself or herself. As teachers or role models, we have to suspend our own perceptions, judgments, and beliefs, and genuinely and respectfully listen to the learner's perspective.

In teaching the first tool and helping young people develop a strong idea about their personal capabilities, there are some critical behaviors we have to give up (Glenn & Nelson, 1989). We must give up assuming that we know how someone else will react in situations and acting as if that were true. We no longer need to rescue or explain, expect attainment of perfection, or dominate and control. Instead, we must learn to listen and hear individual perceptions; check out assumptions; be open to, accepting, and respectful of a young person's thoughts and feelings; and be encouraging and celebrate successes. These changes in adult behaviors will help young people begin to feel valued and respected in the community.

As noted earlier, years ago each family member used to feel that his or her contributions were essential to the family's maintenance and survival. For the most part, this reality has been lost. What has not been lost is the need to be needed. The individual's perception of personal significance is of primary importance. To develop this second tool, we must find ways to acknowledge each individual's personal worth, to help them see that the family is richer because this person is contributing his or her uniqueness. This can be done by listening, understanding, and accepting another's perspective, by soliciting ideas and perceptions from young people, by having frequent personal contact, and by providing a loving, warm family climate.

The third tool, the individual's belief in his or her ability to influence life, refers to the earlier discussion of internal versus external locus of control. Adults can help children build this internal power by establishing firm boundaries for behavior. One of the purposes for maladaptive behavior is to see if limits are real. If an adult cares enough to set limits and adhere to them, the child learns that he or she is valued and loved and knows the parameters within which to make decisions about behavior. At the same time, he or she also learns about the natural or logical consequences of stepping outside of these parameters. Children will learn from their mistakes if allowed to do so. They will build a belief system that says they have influence over their world. As already noted, adults have to be good listeners so there can be continued discussions with the child as he or she matures and encounters new decision-making opportunities.

Intrapersonal skills, the fourth tool, refer to an individual being able to understand and express feelings, to exercise self-control and self-discipline (Glenn & Nelson, 1989). As a child learns to make decisions within established boundaries, in new situations he or she can consider available responses and choose appropriately. The parent who does not allow the child to make a decision, and does it for him or her, is a primary interference here. A better intervention is to provide a list of alternatives, discuss with the child the consequences of each action (from the child's perspective), and allow the child to decide.

Interpersonal skills, the fifth tool, refer to those skills that allow people to communicate with each other. The extent to which a young person learns these skills is closely related to how well they get along with others. Adults can teach these skills through modeling and talking with children.

The systemic and judgmental skills, identified by Glenn and Nelson (1989) as the sixth and seventh tools, are not always specifically taught. They are based on, composed of, and the result of earlier lessons learned. Understanding how the system in which we live works is to become aware of the connection between what we do and the result of our actions. By becoming aware of cause and effect, we learn to predict outcomes and are able to set attainable, realistic goals. We learn to be flexible and to take responsibility for our actions because we know the possible outcomes or consequences. In order for children to learn and increase these skills, adults must provide information about behavior in a caring, respectful climate. Helping an individual to develop good judgment skills requires adults to allow the person most affected by the decision to make it, to provide opportunities for young people to make decisions and experience the consequences, and to collaborate with them during the process. As part of the learning process, we also need to help them evaluate their decisions.

## CASE STUDY: PROJECT REACH

Project Reach is an alternative program for at-risk students in the Socorro School District in Texas (Heger, 1992). Students in this program were in serious trouble in school and had reached the stage where the next step was expulsion. Health education, drama, group therapy, and computer-assisted instruction were blended in a program designed to prevent dropouts or expulsions and to assist in the reintegration of these at-risk students into the mainstream.

The curriculum was a traditional curriculum delivered in a nontraditional way, through computers. In the remaining time during the school day, students participated in health and drug education, drama, and personal log writing. The psychological part of the program is described as similar to "Tough Love" and "Boot Camp," which are highly structured programs that leave no doubt as to limits and consequences of misbehavior.

The school day started at 11 a.m. and continued into early evening, and admission was for an undetermined length of time. Students had levels of tasks to complete, and when these stages were accomplished, they were readmitted into the mainstream. The pace of progress was individualized.

Evaluators found dramatic results. Attrition rates went from 84% in 1990–91 to 2.9% in 1992–92. At the same time, 76% of the students reported better grades. Students were surveyed periodically, and 86% believed the program was helpful to them. The longer they were in the program, the more helpful they reported it to be.

Success of this program is attributed to the design, the staff, and the execution. Staff members were from nontraditional backgrounds, and many had turned to teaching after trying other occupations. Some were not fully certified, but all had prior experience in helping people in nontraditional curricula.

## SUMMARY

In our society, young people daily exhibit deviant behaviors. There is evidence every day that there are many more adolescents demonstrating characteristics that are understood to be at risk. These young people are considered at risk because unless they are helped to succeed, they will become part of the deviant subculture. Research has shown that there is a connection between how a person feels about himself or herself and how that person acts (Kaplan, 1975; Kaplan et al., 1986; Marston et al., 1988). Self-esteem is an issue that must be confronted as a cause of at-risk behaviors.

This chapter identifies specific symptoms of low self-esteem, factors that influence self-esteem and prevention programs, and strategies for parents, individuals, schools, and communities. The activities and programs designed to be used with at-risk youth are not extensive. We must look within our own communities to discover available and successful youth programs. Additional information and resources may also be found in popular magazines (Corbett in *Essence*, 1995; Cordes in *Parenting*, 1994; Herman in *Utne Reader*, 1992; McMahon in *Cosmopolitan*, 1994; McMillan, Singh, & Simonetta in *Education Digest*, 1995; Tafel in *McCalls*, 1992). The goal is to reach all adolescents, particularly those at risk, and give them a chance to succeed and feel worthwhile.

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# 6

# Depression in Childhood and Adolescence: Working to Prevent Despair

*Benedict T. McWhirter, J. Jeffries McWhirter, and Irit Gat*

The incidence and nature of depression during childhood and adolescence has been a topic of some controversy (Esman, 1982). From the traditional psychoanalytic position, depression is a manifestation of conflict between the ego and superego. But neither the ego nor the superego is thought to be fully present before late adolescence (Garrison, Shoenbach, & Kaplan, 1985). Thus for decades, mental health researchers and practitioners discounted the existence of depressive disorders during childhood and early adolescence. Currently, however, depression in youth is viewed as a significant problem that affects approximately 30% of the adolescent population (Lewinsohn, Hops, Roberts, Seeley, & Andrew, 1993). In fact, one in five youngsters report a minimum of one episode of major depression by the age of 18 (Lewinsohn et al., 1993). Furthermore, the prevention of depression in childhood and adolescence is critical to reducing the high cost of treating this disorder among adults (King, 1991). Therefore, child and adolescent depression is a major phenomenon and deserves the full attention of mental health and educational professionals.

This chapter focuses on the problem of child and adolescent depression. First presented are some of the definitional and diagnosic issues in child and adolescent depression. Next, the story of Esteban, a Latino adolescent who is struggling with depression, illustrates some of its causes and related intervention strategies. Some of the causal factors associated with this disorder are discussed, as are the prevention and treatment strategies that have been found to be effective for children and youth suffering from depression. The strategies discussed include family, individual, school, and community approaches. The chapter concludes with an exploration of how the various prevention and treatment strategies discussed can be combined to form a responsible and comprehensive response to young people experiencing depression.

## PROBLEM DEFINITION AND DIAGNOSTIC ISSUES

The clinical syndrome of depression in childhood and adolescence has not been well addressed in the psychological literature. Early concepts, such as *adolescent turmoil* and the *masked depression* model either led practitioners to discount depression or hindered their understanding of depression in childhood and adolescence. For example, adolescent turmoil suggests that all adolescents go through a period of turmoil that may appear to be pathological. But the symptoms of inner unrest and deviant behavior that characterize adolescent turmoil were thought to be a normal part of adolescence and, therefore, clinically unimportant (Garrison et al., 1985). The notion of masked depression also confused, rather than clarified, this clinical problem. This model suggested that although depression is experienced in childhood and adolescence, it is not manifested as such. Instead, it is masked by other behaviors associated with depression, such as irritability and hyperactivity, aggressiveness and delinquency, somatic complaints and hypochondriasis, anorexia nervosa, obesity, poor school performance, school phobia, loss of initiative, social withdrawal, and sleep difficulties (Carlson, 1981; Carlson & Cantwell, 1980; Davis, 1983; Husain & Vandiver, 1984).

Current research, however, challenges these concepts. For example, no common picture of adolescent turmoil has emerged, and no consistent period of difficult psychological adjustment seems to exist. Indeed, similar behavioral manifestations of turmoil may be found in adult populations, and many adolescent problems or maladjustments are not transitory at all but lead to significant disturbances in adulthood (Garrison et al., 1985). Likewise, masked depression is difficult to validate, is controversial, and has been refuted by research (Carlson & Cantwell, 1980; Kovacs & Beck, 1977). *Masking behaviors* are actually better conceptualized as presenting complaints that to the astute clinician will not be classified as other problems but seen as symptoms of depression. These criticisms have led to current acceptance in the research literature that depression exists across all age groups (Puig-Antich, 1982; Reynolds, 1984). Given this consensus, it is appropriate to further describe the procedures for the diagnosis of depression among young populations.

For the last four decades, the most widely used diagnosis and classification system has been the *Diagnostic and Statistical Manual of Mental Disorders*. The revised, third edition of the manual, the *DSM-III-R*, was published in 1987 (American Psychiatric Association, 1987). The *DSM-III-R* system of classification helped to ameliorate the problems and controversies associated with general classification concepts such as adolescent turmoil and masked depression. Such clarification was accomplished by providing a description of the diagnostic categories of depression without projecting specific philosophical orientations or presenting specific arguments regarding depression classification

(Coyne, 1986; Levitt, Lubin, & Brooks, 1983). The *DSM-IV*, published in 1994, added further clarity to the diagnosis of depression in childhood and adolescence (American Psychiatric Association, 1994).

The *DSM-IV* has addressed differential aspects of adolescent depressive symptomology as opposed to common symptoms experienced or evident in adults. In addition, further symptom delineation has been made between prepubescent children and adolescents. For example, children commonly display irritable mood rather than depressed mood, somatic complaints, and social withdrawal. Depressed adolescents typically display psychomotor retardation and hypersomnia.

Prior research indicated that depressed adolescents do show different symptomology than adults, including fewer suicide attempts and behaviors (Hawton, 1986), more social withdrawal (Kovacs, Feinberg, Crouse-Novak, Paulauskas, & Finkelstein, 1984), more irritability (Puig-Antich, 1987), and fewer verbal expressions of depression or guilt (Puig-Antich, 1987). The *DSM-IV* noted that prepubertal children typically display major depressive episodes in conjunction with disruptive behavior disorders, attention-deficit disorders, and anxiety disorders. Adolescent depression is more commonly associated with disruptive behavior disorders, attention-deficit disorders, anxiety disorders, substance-related disorders, and eating disorders.

As compared to the *DSM-III-R*, the *DSM-IV* has made numerous changes and additions in the classification of mood disorders. Specifically, in the *DSM-IV* the mood disorders are divided into three major categories: depressive disorders, bipolar disorders, and mood disorders due to a general medical condition. The depressive disorders include major depressive disorder, characterized by one or more depressive episodes without history of mania, and dysthymic disorder, characterized by conditions indicating mood disturbance that has been chronic or intermittent for at least 2 years but without the degree of severity to warrant a diagnosis of major depressive disorder. Bipolar disorders include bipolar I disorder, bipolar II disorder, and cyclothymic disorder. The bipolar disorders are distinguished by the presence of a manic episode. Cyclothymia, a milder form of bipolar disorder, is indicated by the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet the criteria for a major depressive episode. The final category includes mood disturbances judged to be of medical etiology. This condition is found with increasing frequency among younger populations. The *DSM-IV* also included seasonal pattern indicators (such as seasonal affective disorder) in which people become more depressed during certain times of the year. Practitioners should also pay attention to adjustment disorders that may be accompanied by depressed mood as another important diagnostic category. In sum, the *DSM-IV* can be a useful tool for the clarification and diagnosis of childhood and adolescent depression. It certainly can be helpful for assisting the young man in the following story.

## CASE STUDY: ESTEBAN'S STORY

Esteban was a 15-year-old Mexican American high school sophomore who was referred to counseling at a community mental health center by his mother after he threatened to kill her with a kitchen knife. He had straight black hair—long on top and shaved from 1 inch above his ears on down. He had crooked teeth, jeans that were fashionably oversized, and an untucked flannel shirt. Esteban attended a school where the majority of students were European American from middle-class backgrounds. In our first session, Esteban sat silently and played with his hands while his mother provided information about the family and described her concerns.

Esteban had two sisters, Reynalda (Reina), age 16, and Catalina, 13. His mother, Irma, and his father, Reynaldo, were married when they were 18 and 20, respectively. According to Irma, Reynaldo began a series of extramarital affairs shortly after Esteban was born. He had always been a heavy drinker, and he lost his job with the mining company after "too many Monday flus." The family environment described by Irma included harsh and inconsistent discipline by Reynaldo and guilt-induced permissiveness by Irma, in a context of poverty, frequent moves, and anxiety regarding Reynaldo's next binge. On several occasions, Reynaldo hit Irma in front of the children and was frequently verbally abusive toward her. Irma had finally divorced Reynaldo 3 years ago, and within 2 months he was remarried to an 18-year-old. Currently, Irma was working the 3 to 11 p.m. shift at a factory. Reynaldo's contact with his children since the divorce had been intermittent. Reina and Esteban "hated" his new wife, Tina, and Reynaldo refused to spend time with them apart from Tina.

Irma described Esteban as a sweet little boy who had grown into a monster like his father. When he entered high school 1 year ago, his average grades began slipping, he started to smoke, and he skipped classes. Whenever Irma confronted him, she reported that Esteban used the same verbally abusive language that his father used, such as "It's none of your business, you dirty whore." He refused to help out around the house and spent most of his time locked in his room listening to Madonna tapes with "a girl who dresses like a boy." When asked whether she had concerns about sexual activity between Esteban and this young woman, Irma said scornfully, "Even if she did want it—and that girl don't want it—he wouldn't know what to do." Esteban visibly flinched as she said this—his first overt reaction since arriving in the office.

Irma made the appointment for Esteban after an argument in which he shouted "If you don't leave me alone, I'm going to come after you with that big old knife. Everybody hates you, and if I killed you they would laugh." Irma said that although she didn't think Esteban would kill her or even attempt to hurt her, she was frightened by the hatred in his voice. When asked what she hoped counseling would accomplish, she said "Find my sweet little boy and bring him back to me."

The remainder of that first session was spent alone with Esteban. As soon as his mother left, he asked if he could smoke. That was his only question and his only spontaneous communication. It quickly became obvious that he was painfully shy, embarrassed, and very nervous. His brief answers to my questions did not seem to convey hostility or resentment but a profound sense of frustration and inadequacy. The additional information that slowly emerged in the one-on-one meeting included the following: His mother had a string of boyfriends, none of whom he liked; he communicated very little with his siblings and knew nothing of how they felt or how they saw things; he had only one friend—the aforementioned "girl who don't want it"—who did, in fact, "want it" but so far had only permitted him to lie in bed naked with her. This they did regularly while listening to Madonna tapes and smoking cigarettes. When asked how he felt toward others—his mother, teachers, people at school—he stated, unconvincingly, that he hated them. He frequently stated, more convincingly, that he didn't care or didn't know about much of what was going on around him most of the time.

In subsequent sessions, Esteban began to communicate more openly, using longer sentences and asking more questions. It was clear that Esteban lacked many basic social skills. He spent much of his time at home while his mother worked. Often, her current boyfriend would hang out there while she worked. He didn't like this, but it was the only time that he would talk with his sisters—they would hang out in his room to avoid the boyfriends. There were no indications of any attempted sexual contact between any of the boyfriends and the three children. Esteban indicated that he was embarrassed to ask his teachers for help and so never tried to talk to them. He also reported that he felt responsible for his father's behavior—that if he wasn't the way that he was, his father would not have been a drunk and been so violent.

Esteban seemed to hate himself as much, if not more, than others around him. He was clearly experiencing a great deal of pain, frustration, guilt, and depression. Although he did not want to feel so isolated from others, he felt "stuck" and had never been taught the skills to move forward.

## CAUSAL FACTORS

Esteban's depression could have been caused by any number of factors. In this section, some of the more central causal and conceptual models of depression—biological, psychodynamic, behavioral, cognitive, and family—and how each of these models might apply to Esteban are described. In the next section, how these causal models flow into effective prevention and treatment is discussed.

## Biological Models of Depression

Biological models of depression can be divided into two main categories: those that focus on the role of genetic factors and those that emphasize biochemical aspects of depression. Genetic factors in depression have been examined through twin/adoption studies among adults. Research has provided some interesting evidence for a genetic component of depression. For example, there is an average concordance rate of 76% for affective disorders in identical twins versus 19% for nonidentical twins (Kashani et al., 1981). Also, adoptees who experienced greater depression were more likely to have biological parents who suffered from an affective disorder. The specific nature of genetic transmission has not been determined, nor has the role of genetic factors in the etiology of depression among adolescents been systematically researched.

Another biological model of depression focuses on biochemical processes. Neurotransmitter actions and their interactions with antidepressant medications have been the focus of much biochemical research on depression. Whether a primary cause of depression or a secondary component, some evidence suggests that abnormalities in the metabolism of neurotransmitters are present in people who are depressed and can be counteracted with antidepressant drugs (Kashani et al., 1981).

In Esteban's case, evidence suggests that both of his parents may have experienced depression. His mother's patterns of developing relationships and his father's alcoholism and abusiveness both support the notion that they suffered from a lack of coping skills and poor self-esteem—which is almost always a concomitant of depression. The weakness of this model in explaining Esteban's depression is that it does not attend to the profound impact of Esteban's environment in forming his behavior and feelings about himself and others.

## Psychodynamic Models of Depression

According to the classical analytic model of depression, a distinction is made between grief, a normal response to loss of a love object, and melancholia, an intensely ambivalent love-hate relationship resulting from the real or imagined loss of a love object. Individuals predisposed toward melancholia are highly dependent. This dependency creates hostility toward the focus of the dependency, but these negative feelings of anger are repressed and ultimately converted into self-hostility. Depression results from the negative impact of this anger turned inward on the self. The reliance of this model on untestable, intrapsychic constructs has prevented its validation. Nevertheless, the psychoanalytic perspective provides an important conceptualization of the depression phenomenon that can be useful for practitioners.

For example, in Esteban's case, the guilt and feelings of loss that he feels toward his father may cause him to blame himself for the family's problems. His guilt and loss are confused with feelings of anger toward and abandonment by both parents. These feelings, over time, have been turned inward and have severely damaged Esteban's self-esteem. Thus he becomes depressed. In order for Esteban to resolve his depression, he must recognize the loss he has suffered and express his feelings directly instead of turning them in on himself.

## Behavioral Models of Depression

Similar to the psychodynamic model, behaviorists view depression as a result of significant loss (Kovacs & Beck, 1977; Schwartz & Johnson, 1985). Whether this is through changes in the environment, the loss of a reinforcing interpersonal relationship, or failure to encourage and arrange for positive reinforcement, depression is seen as the consequence of inadequate or insufficient reinforcement (Ferster, 1973; 1974).

Lewinsohn's social learning theory provides a concise behavioral model of depression. This theory suggests that depressive behaviors are determined by the presence or absence of reinforcers and maintained through the reduction of response-contingent reinforcing events (Lewinsohn & Hoberman, 1985). Depression may be the result of limited positive reinforcement for the individual, which is determined by the number of potentially reinforcing events, the number of these events available in the environment, and the individual's social skills to elicit accessible reinforcers (Levitt et al., 1983). Depression may also result from an excess in punishment, especially when it occurs at high rates, when the individual is highly sensitive to punishment, and when necessary coping skills to terminate punishment are limited (Lewinsohn & Hoberman, 1985). Unfortunately, the depressive behaviors stimulated by inadequate reinforcement are further reinforced by the concern or sympathy expressed by significant others. Eventually though, others avoid the depressed person because of the nature of his or her depressive behaviors, which minimizes positive reinforcement and further exacerbates the depression (Lewinsohn & Hoberman, 1985).

To illustrate this model, Esteban receives almost no positive reinforcement, except perhaps from his female friend. Further, his lack of social skills does nothing to elicit positive reactions from others. On the contrary, his surly manner elicits negative reactions from others, so that he never receives the social reinforcement he so desperately needs to help lift his feelings of depression. He feels more and more isolated, less liked by others, and subsequently more depressed.

## Cognitive Models of Depression

Research has also supported the role of cognition in depression (Beck, 1967; Rehm, 1977; Seligman, 1974, 1975). Three cognitive models of depression are helpful in understanding this perspective.

The first model, proposed by Beck (1967), suggests that cognition and affect are interactive, and that the prior occurrence of cognition determines a person's affective response to an event. If cognitions are distorted or inaccurate, the individual's emotional response is inappropriate. Dysphoria may be the affective response of an individual's tendency to interpret experiences and events as negative or self-devaluative, indicating a cognitive role in the experience of depression.

Beck, Rush, Shaw, and Emery (1979) pointed to three cognitive components central to depression: the cognitive triad, schemas, and cognitive errors. The cognitive triad are three negative thought patterns: a negative view of self, of the world, and of the future. Schemas, like personality traits, represent a stable cognitive pattern that individuals create in order to organize and evaluate information and events. People who experience depression develop schemas that distort environmental stimuli to coincide with a derogatory self-image. These dysfunctional or negative schemas are often created and exacerbated by faulty information processing, or consistent errors in logic, called *cognitive errors*. The person suffering from depression uses these automatic cognitive errors to evaluate events, often leading to negativistic, categorical, absolute, and judgmental thinking (Levitt et al., 1983; Lewinsohn & Hoberman, 1985).

The second model of depression, Seligman's (1974, 1975) learned helplessness model, contends that depression exists in people who perceive that they have no control over their environment. They develop self-defeating attributions. They make internal (feeling responsible for an event), stable (the causes of an event remain constant), and global (event outcomes impact all areas of life) attributions for failure. In contrast, they attribute successful outcomes to external (caused by others), unstable (causes of events are transitory), and specific (situation specific) causes (Kaslow & Rehm, 1983). According to this model, this self-defeating attributional style results in the lowered motivation and reduced self-esteem common in depressed clients (Kaslow & Rehm, 1983). Self-defeating attributional style has been correlated with depression (Lewinsohn & Hoberman, 1985).

The third cognitive model of depression is represented by Rehm's (1977) self-control theory. Problems of self-control are manifested through deficits in three cognitive processes: self-monitoring, self-reinforcement, and self-evaluation. Depressed clients fail to view situations with an orientation to the future, and tend to concentrate on immediate consequences of events (Gilbert, 1984). They selectively attend to negative outcomes and focus on immediate reinforcements. A negative view of the self, the environment, and the future results.

Similarly, depressed individuals tend to attribute negative events to either external causes beyond their control or to internal, unchangeable deficits in the skills that are necessary to create change. They tend to set high standards for positive self-evaluation and at the same time have low standards for negative self-evaluation. Reduced self-esteem and increased feelings of helplessness and depression result from these maladaptive structures of self-evaluation (Lewinsohn & Hoberman, 1985).

In accord with this model, cognitions play a key role in Esteban's depression. For example, Esteban maintains the faulty belief that he is responsible for his father's behavior and for the demise of his family. Likewise, he attributes negative outcomes to deficiencies in himself (a negative internal attribution) instead of to the dysfunctional family and unstable economic environment around him. An effective intervention for Esteban must focus on these and other self-destructive and self-defeating cognitions.

## Family Models of Depression

Finally, an ecological approach to understanding the development of childhood and adolescent depression is to attend to family dynamics and the family environment. These dynamics are of considerable importance. Proponents of this perspective suggest that young people who experience depression are symptoms of family malfunction. The homeostasis of a maladaptive family system is maintained when a child or adolescent performs the role of the sick family member. In accord with this model, other family members often resist any positive change in the adolescent because it risks upsetting the homeostasis of the family. This reality necessitates the involvement of the entire family system in treatment interventions (Guttman, 1983).

For Esteban, it seems critical that his entire family be involved in the treatment process. Although Esteban's concerns may be more acute right now, his sisters are both at risk for a variety of behavioral problems as well. Family intervention may help to not only resolve his issues but also prevent future problems among the other siblings. Furthermore, the behaviors and messages of Esteban's mother and father must be explored in order for each family member to recognize the resulting consequences. Clearly, the ideal is for Esteban's mother and father to be involved in treatment and to make changes. But if his father is no longer involved with the core family, at least Esteban's mother needs to understand and modify her patterns of communication and behavior. It is also important that the entire family receive support and validation in treatment, especially given the economic marginalization and racial victimization they experience. If family members are unwilling to be involved in treatment, any intervention focused solely on Esteban is likely to be ineffective.

## APPROACHES TO PREVENTION AND TREATMENT

A conceptual model for understanding and intervening with at-risk youth has been proposed by McWhirter, McWhirter, McWhirter, and McWhirter (1993).

This model is based on two key assumptions: (a) being at risk for problematic behavior reflects not only a current condition but also an element of prediction for future problems and (b) at-riskness must be viewed not so much as discrete and unitary but rather as a series of steps along a continuum. This continuum begins with youth who are at *minimal risk* for problematic behavior, proceeds through *remote risk*, *high risk*, and *imminent risk*, and ends with youngsters already engaged in *category activity*. Category activity refers to participation in one or more destructive behaviors such as drug use, delinquent activity, and sexual promiscuity. A youngster's placement along the at-risk continuum is mediated by demographics, family and school environments, psychosocial stressors, and personal characteristics of the youth. This model also proposes that prevention, early intervention, and treatment must involve the family, school, and community. In short, interventions must attend to current problems, to the potential for future difficulty, and to multiple aspects of a young person's life.

Using the McWhirter et al. (1993) model, for example, Esteban can be considered at imminent risk. He has a very negative family environment, comes from a poor socioeconomic background, experiences a great many psychosocial stressors including subtle and direct racial discrimination, and does not have effective coping skills or clear goals for his future. Further, he has already developed gateway behaviors, such as smoking, being sexually explorative, and having violent outbursts, that highly predict category behavior.

In accord with this model, practitioners should (a) use generic skills training prevention programs for children in early elementary grades, (b) move into more focused and topic-specific prevention/intervention efforts for youth around middle-school age or earlier if risk factors demand it, and (c) use more topic-specific treatments and second-chance programs for older youth or youngsters already engaged in category activity. At the prevention end of the continuum, efforts are focused on the building of general skills, such as assertiveness, communication, recognizing feelings, and resolving conflict. At the treatment end of the continuum, interventions are focused on resolving specific problems that are already developed, such as depression, drug use, or delinquency, as well as on techniques that enhance a broad range of skills in order to prevent more serious problems from emerging as youth become young adults. For instance, Esteban needs treatment focused specifically on his depression and on its root causes but also focused on helping him develop skills for dealing with future problems in a wide range of areas. He could be helped by interventions for the entire family, by cognitive and behavioral strategies focused on him individually, by school intervention programs, and by community-based treatment approaches.

The core components of prevention as well as more specific treatment strategies can be applied to youth at risk for depression. These prevention and treatment strategies focus on the family, individual, school, and community.

## Family Approaches to Prevention and Treatment

The role of the family in the successful treatment of the depressed child or adolescent is crucial. Counselors using only an individually based intervention strategy may, in fact, be doomed to failure because from this perspective the entire family needs to change its system. Mental health workers must also be aware that normal nurturance and family care may not be effective in dealing with the depressed child or adolescent (Robbins & Kashani, 1986). Clinicians must be prepared to work with all family members, especially parents who may also suffer from an affective disorder, in order to be successful. In Esteban's family, if his mother and sisters are not engaged in treatment, he is likely to continue to suffer from the same environment that contributed to his depression in the first place.

In many circumstances parent training can benefit the family and help prevent depression and other problems. Workshops for parents can be particularly useful and cost effective, especially those that focus on developing communication skills, enhancing family interactions, and sharing information about issues (such as birth control and signs of drug use). Workshops also offer parents a forum for discussing fears, concerns, and frustrations with other parents and with a professional facilitator. These types of training can increase parental confidence and comfort with discussing many issues with their children. With greater dysfunction, therapeutic programs attending to child abuse and neglect, parental dysfunction, and family violence may also be extremely beneficial.

Parent training may be utilized as prevention as well as treatment for many problems. In addition to childhood and adolescent depression, parent training topics of interest to many families include behavioral management and discipline, sex education, nutrition, family budgeting, and prevention of chemical dependency (DeMarsh & Kumpfer, 1986).

Parent effectiveness training (PET) and family effectiveness training (FET) are two models of parent training that have proven to be very effective for preventing depression. These programs have also been reviewed elsewhere as methods of empowering youngsters via counseling (McWhirter, 1994).

***Parent effectiveness training.*** Parent effectiveness training (Gordon, 1975, 1977) is a method of parent training based on the Rogerian principles of positive regard and empathy. PET combines lectures, role-playing, readings, and homework exercises to train parents in confrontation skills, conflict resolution, active listening, and giving "I" messages. Parents have the opportunity to practice and refine each of these skills throughout the sessions. Ultimately, problems in the family are handled more constructively and with more open and healthy communication.

***Family effectiveness training.*** Szapocznik, Santisteban, Rio, Perez-Vidal, and Kurtines (1986a, 1989) developed a preventative training model for Hispanic families of preadolescents at risk for future drug abuse. FET can also be modified to deal specifically with other child and adolescent behavior problems. The entire training consists of 13 sessions that last from $1\frac{1}{2}$ hours to 2 hours; the entire family is present for each session. Family effectiveness training is designed to address three problems that often serve as antecedents to adolescent behavior problems: maladaptive family interactions, intergenerational conflict, and intercultural conflict. It is one of few empirically tested programs that directly addresses cultural differences. The model has three components.

The first component, *family development*, helps the family to negotiate the childhood-to-adolescence transition. All family members learn constructive communication skills and take increased responsibility for their own behaviors. Parents become educated about drugs so that they can teach their children; they also learn the skills to become democratic rather than authoritarian leaders.

The second component, *bicultural effectiveness training* (BET) (Szapocznik, Santisteban, Kurtines, Perez-Vidal, & Hervis, 1984; Szapocznik et al., 1986b), is designed to bring about family change by (a) temporarily placing the blame for the family's problems on the cultural conflict within the family and (b) establishing alliances among family members through the development of bicultural skills and mutual appreciation of the values of both cultures. The family learns to handle cultural conflicts more effectively, and the likelihood that such conflicts will occur is reduced. BET represents an excellent parent training program in and of itself. This program could be particularly helpful for Esteban's family, whose members contend with acculturation issues and overt and covert racism on a daily basis.

The third component of FET is the implementation of *brief strategic family therapy*. Based on the work of Minuchin (1974), this component involves a series of family therapy sessions and is the most experiential aspect of this didactic/experiential model.

Parental training programs will be helpful for Esteban, but because he already shows clear signs of depression, direct therapeutic intervention with the whole family is called for. Helping Irma and her children communicate more effectively with each other has the potential of creating a great deal of change in the family. In addition, helping each of the children to see his or her value and significance in the family is important. The family can become a primary source of support and encouragement when family members can share their needs, wants, and feelings more effectively.

## Individual Approaches to Prevention and Treatment

Counselors and other mental health and education professionals in diverse settings can typically pursue individual approaches to prevention and treatment, and practitioners should follow their own orientation in attending to child and adolescent depression. The focus here is on cognitive-behavioral approaches that can be preventive and that have been effective with individuals already suffering from depression. A discussion of pharmacological intervention, another individualized treatment, is included.

Cognitive-behavioral treatments for depression flow directly from the cognitive and behavioral models described earlier in this chapter in the discussion of causal factors. For example, Beck et al. (1979) developed a therapy with both behavioral and cognitive components designed to reduce automatic negative cognition with the goal of challenging the assumptions that maintain these faulty cognitions. Because clients often have difficulty utilizing cognitive tasks, behavioral strategies should be used first in the therapeutic process. Similarly, positive activities should be established and augmented through role-playing, graduated task assignments, assertiveness training, activity schedules, and behavioral rehearsal before cognitive interventions are employed (Lewinsohn & Hoberman, 1985).

Behavioral strategies are important because depression results not only from the limited reinforcement of poor social skills but also from the lack of reinforcement that occurs when sufficiently learned and appropriate social skills are not utilized (Kaslow & Rehm, 1983). Increasing an individual's activity level and, therefore, the frequency of potentially rewarding activities may also increase the level of response-contingent reinforcement. This process may, in turn, reduce the behavioral symptoms associated with depression (Kaslow & Rehm, 1983). This behavioral intervention appears to be very appropriate for Esteban. Unless he becomes more involved in more positive peer interactions and in pleasant activities, he may have great difficulty in improving his depressed mood and in learning more positive cognitions.

Programs designed to increase activity levels include establishing a mood/activity baseline, identifying current positive activities, increasing activities that are potentially reinforcing, decreasing activities associated with negative mood, and establishing environmental contingencies to reinforce both increased positive and decreased negative activities (Kaslow & Rehm, 1983). Scheduling more activity and using either self-managed or externally controlled reinforcement programs also help to increase positive activities.

After these strategies are successfully utilized, emphasis is moved to cognitive interventions that emphasize identifying, testing, and modifying cognitive distortions. Strategies that have been successfully used include (a) recognizing the connection between cognition, affect, and behavior; (b) monitoring negative automatic thoughts; (c) examining evidence related to distorted automatic cognition; (d) substituting a more realistic interpretation for distorted cognition; and (e) learning to identify and modify dysfunctional beliefs (Ellis, 1962; Ellis & Bernard, 1983; Kaslow & Rehm, 1983; Kolko, 1987). Such strategies could be implemented with Esteban as part of individual treatment. Of course, these strategies could also be used as part of a prevention program in the school setting.

Another intervention is Seligman's (1981) treatment approach, which is an outgrowth of his learned helplessness model of depression. It challenges the faulty attributions of control and efficacy that depressed individuals often make (Kolko, 1987). Focus is placed on enriching the environment to assist in effecting more desired outcomes while decreasing unwanted ones, developing expectations of control through control training, reducing preference for unobtainable outcomes through resignation training, and changing attributions to replace unrealistic ones.

The final cognitive-behavioral approach for depression is based on Rehm's self-control model. This intervention has been described as a primary prevention method, useful in teaching the skills necessary to avoid depression (Kaslow & Rehm, 1983). Kolko (1987) recommended that treatment in self-control involve specific training to, for example, monitor positive events and self-statements, engage in positive behaviors and cognitions, emphasize long-term positive consequences and develop more realistic and achievable goals, make more legitimate attributions, and create more frequent self-reinforcement. In Esteban's case, the depression is current. Devising ways to help him increase his positive and decrease his negative self-talk is important.

There are two cognitive-behavioral techniques that we have found to be particularly helpful. First, ask the child or adolescent to repeat a standard, positive phrase, such as "I am a good person" every time he or she takes out a pen from his or her backpack. Second, ask the client to write down on three-by-five cards a positive, affirming self-statement (e.g., "I am an honest and decent person," "I am attractive and caring."). When three or four cards are completed, add one blank card and place them inside the client's class notebook. Each time the notebook is used, the client silently reads one of the cards. When the blank card turns up, the client must spontaneously make up a new, positive sentence.

Pharmacological interventions are, in some cases, required with depressed clients. Since the 1960s, trycyclic antidepressants have been prescribed for young patients (Hodgman, 1985). Monoamine oxidase (MAO) inhibitors and lithium carbonate have also been used to a lesser degree (Reynolds, 1985). Although frequently used in the clinical setting, the effectiveness of antidepressants has not yet been completely established through controlled research. Uncontrolled studies have reported positive results (Robbins & Kashani, 1986), but antidepressant use with children and adolescents should be carefully monitored. Counselors and psychologists need to have a referral network available so that this aspect of treatment is not neglected.

A combination of pharmacological intervention and therapy might be most useful with some adolescent clients suffering from depression (Cytryn & McKnew, 1985). In the case of bipolar disorders it is probably essential. The effectiveness of lithium carbonate with this type of depressive disorder has been well established. Of course, during a severe manic episode the behavior often causes problems that result in hospitalization. With adolescents, counselors and other practitioners need to be attentive to less severe mood swings or problems with a view to referral. Although the existence of a bipolar disorder does not seem probable in Esteban's situation, a medical referral for his depression may still be important.

## School-Based Approaches to Prevention and Treatment

The increased rates of depression among children and adolescents support the need for early prevention and intervention in the school setting (Forrest, 1983). In fact, schools are an ideal setting for prevention: most children and youth can be reached, and most can be taught critical life skills as an integral part of the curriculum. Training in life skills can reduce existing problems as well as prevent more serious ones from occurring. As such, school-based programs can prevent child and adolescent depression and many other problems.

In responding to depression, school-based prevention programs engage multiple strategies. School counselors should use depression assessment instruments. To be effective, assessment should consider the youngster's cognitive and affective characteristics, environmental stressors, and current coping mechanisms (Forrest, 1983). School prevention and treatment should also include a mixture of affective, cognitive, and behavioral strategies, an approach that has been found to be effective (Coats & Reynolds, 1983). Further, group interventions are central to many school-based prevention programs because of their ability to reach a large number of children and their adaptability to the classroom format.

Early prevention in the schools can take the form of educational programs focused on forming friendships, nonviolent conflict resolution, assertiveness, relating to adults, and dealing with peer pressure. Broad-based skills training programs such as these not only prevent depression but also help to prevent other critical problems faced by youth, such as teenage pregnancy and drug use. Schools are important focal points in building these prevention programs because they provide access to both families and communities. In Esteban's case, such programs might have provided the social skills training that he did not receive at home.

The core components of good prevention programs, that is, training in life skills, include interpersonal communication, strategies for cognitive change, coping with stress, and managing health (McWhirter et al., 1993). Life skills are those that involve behaviors and attitudes necessary for coping with academic challenges, communicating with others, forming healthy and stable relationships, and making good decisions. Life skills training programs emphasize the acquisition of generic social and cognitive skills. The theoretical foundation of life skills training includes Bandura's (1977) Social Learning Theory and Jessor and Jessor's (1977) Problem Behavior Theory. In accord with these perspectives, children and adolescents are not blamed for causing their problems, but are viewed as capable of learning new ways to behave that reduce the likelihood of future problems.

Counselors and other mental health professionals can all be involved in teaching life skills. Procedures for teaching life skills resemble those used in the teaching of any other skill. Overall tasks are broken down into smaller stages or component parts and taught systematically, moving from simple to more complex skills. Each life skills session follows a five-step model: instruction (teach); modeling (show); role-play (practice); feedback (reinforce); and homework (apply). Within this general framework, steps may be modified in accord with the needs of the group. Three broad skill categories are usually included in basic life skills programs:

- *interpersonal communication skills*, including assertiveness and refusal skills;
- *cognitive change strategies*, including problem-solving, decision-making, self-management and self-control skills, and cognitive-behavioral restructuring approaches; and
- *anxiety coping approaches*, including relaxation, imagery training, and exercise.

Learning effective social skills is core to life skills training because it improves and increases the positive feedback and reinforcement that is received from others (Lewinsohn, Biglan, & Zeiss, 1976). Treatment here focuses on the improvement of interpersonal style and on the development of skills, such as improved eye contact (Kaslow & Rehm, 1983). Modeling, feedback, role-playing, instruction, situation logs, and homework practice are all utilized to help augment social skills and minimize the depression caused by an inability to elicit positive consequences. The prevalence of social skills deficits and the results of social skills training among children and adolescents have received limited attention. Nevertheless, such an approach seems especially appropriate for Esteban. Given the fact that he has had relatively little peer group interaction, preferring to be by himself, he has not developed effective social skills with his peer group. Indeed, he seems unable to cope with the responses of his classmates and family. Thus social skills training should be a useful strategy to help lift his depression.

Life skills training can also be achieved through leadership training programs. For example, students provided with leadership opportunities exercise decision-making skills and learn the importance of self-control (What schools can..., 1987). Some researchers have found positive effects from improving adolescent students' problem-solving and decision-making skills (Beyth-Marom, Fischhoff, Jacobs, Furby, 1989). Specifically, schools have reported marked reduction in disruptive behaviors after teaching students to mediate disputes on their own (Lane & McWhirter, 1992). The ability of students to solve their own problems and peacefully settle disputes directly and positively impacts student climate and reduces the likelihood of violence. The development of school mediation programs has been especially helpful in this regard.

School peer mediation (Lane & McWhirter, 1992; Schrumpf, Crawford, & Usadel, 1992) is a mode of student conflict management employed by students for the purpose of resolving conflicts. Trained peer mediators work in pairs to facilitate problem solving between disputants. Student involvement in the mediation process insures practice with critical thinking, problem solving, and self-discipline, all skills that prevent depression and other problems. The element of student participation in self- and peer-behavior change is directly related to the developmental construct of self-regulation. Further, awareness of socially approved behaviors is a critical feature of the concept.

In a similar way, peer counseling (sometimes referred to as peer leadership, peer mentoring, or peer helping) provides a helpful tool for increasing the impact and efficiency of prevention programs. Peer counseling is a process in which trained and supervised students perform interpersonal helping tasks—listening, supporting, providing alternatives, and other verbal and nonverbal interactions—that qualify as counseling functions with similar-aged clients who either have referred themselves or have been referred by others. Peer mediation and peer counseling programs help diminish the negative effects of peer pressure and promote more positive norms for adolescent behaviors (Corn & Moore, 1992; Garner, Martin, & Martin, 1989).

Interpersonal communication skills center around training in verbal and nonverbal communication and focus on healthy friendships, avoidance of misunderstandings, and development of long-term love relationships. Training in general assertiveness, an important part of effective communication skills, is a psychoeducational procedure designed to help adolescents deal effectively with others. Assertiveness training helps reduce the maladaptive anxiety that prevents adolescents from expressing themselves directly, honestly, and spontaneously. Nonverbal communication such as loudness of voice, fluency of spoken words, facial and body expression, and eye contact are important components of the way a message is delivered and interpreted.

Cognitive-behavioral strategies are seen as vital components of an individual's emotional health. Early exposure to cognitive techniques allows for a lifetime of practice and mastery of skills that have been shown to be highly effective in many types of mental difficulties including depression. Cognitive restructuring, self-management, self-control, problem solving, and decision making are important components. The cognitive approaches discussed in the section on causal factors are central here.

Stress and anxiety affect many young people. Techniques that enhance their ability to cope with and reduce stress and anxiety can be an important part of preventing depression. Specific techniques include relaxation training, biofeedback, autogenic training, meditation, the quieting reflex, affirmations, and guided visual imagery.

Finally, exercise, nutrition, and additional self-care habits are helpful but often ignored in prevention efforts. In a study by Brown, Welsh, Labbe, Vitulli, and Kulkarni (1992) a group of psychiatrically institutionalized adolescent boys and girls were assigned to a 9-week aerobic exercise program. The treated girls showed lower incidence of depression, anxiety, hostility, confused thinking, and fatigue, and both the adolescent males and females in the aerobics program showed improved vigor and self-efficacy. The added benefits of employing exercise and nutritional strategies with youth are multifold because forming healthy habits early in life is easier than changing habits later in adulthood.

School-based small group intervention programs for depression and other psychosocial problems have not often been rigorously evaluated, but existing outcome studies indicate some positive results. Groups to help adolescents deal with parental divorce have proven to be effective in ameliorating loneliness (Lesowitz, Kalter, Pickar, & Chethik, 1987) and have helped raise self-esteem and a sense of control in life (Omizo & Omizo, 1987). Groups for violent youth have also shown several positive effects in reducing school behavior problems (Roth, 1991). However, although such results are promising, more research is needed.

## Community Approaches to Prevention and Treatment

Many of the family, individual, and school approaches for the prevention and treatment of childhood and adolescent depression discussed in this chapter could easily be employed by counselors, psychologists, social workers, and other mental health professionals who work in community treatment agencies. But approaches that specifically involve the larger community acknowledge the role of the larger context in which depression and other problems of childhood and adolescence emerge. This section focuses on a larger community program. Given the high correlation between delinquency and depression (McWhirter et al., 1993), Teencourt, the community program described here, can be seen as both a treatment and as a prevention measure for depression and other concerns.

Teencourt is used in Gila County, Arizona, for first-time juvenile offenders between the ages of 8 and 17 who have committed a misdemeanor offense, status offense, or minor traffic violation (McWhirter, 1994; McWhirter et al., 1993). The Teencourt program models an empowerment philosophy and incorporates leadership skills, critical thinking, career exploration, taking responsibility, and influencing peer norms. Youth referred to Teencourt have a choice of (a) pleading guilty, participating in the program, and keeping their record clean, or (b) going through the traditional juvenile court system. Teencourt sentencing is designed to fit the offense, and usually includes community service, tutoring, attending workshops, and/or traffic survival school.

Each session of Teencourt lasts 4 months and involves six attorneys, 20 jurists, one court clerk, and three bailiffs, all of whom are trained high school students. Thus offenders passing through Teencourt are tried by their peers; the judge is the only adult representative of the legal system. All defendants are required to serve a term of jury duty after their own sentencing. This is consistent with the goals of Teencourt, which include preventing repeat offenses among those who are tried, preventing first time offenses among the many students who voluntarily participate (as attorneys, jurists, clerks, and bailiffs), educating adolescents about the legal system, and utilizing peer pressure to evoke conformity to positive behaviors. The recidivism rate for Teencourt participants is well below both state and national averages (McWhirter, 1994).

Thus far, Esteban has not been accused of any legal violation. However, his involvement in some offense will not be surprising given his current alienation, anger, and apathy. Participation in a program such as Teencourt as an offender and then as a jury member could have a considerable positive effect. Teencourt's philosophy of empowerment is manifested in a variety of ways: by increasing adolescents' awareness of the legal system; by providing specific skills training as well as the broader experience of leadership; by utilizing peers—of equal power status—rather than adults; by involving adolescents with community organizations; by tailoring sentences to individual offenses; and by emphasizing responsibility for behavior (McWhirter, 1994). In the context of Seligman's 1974 model of learned helplessness, the Teencourt program adresses many of the deficiencies and apathetic responses from which Esteban suffers.

## Comprehensive Intervention for Esteban

Esteban is a depressed 15-year-old who needs attention and support. For him and for other depressed youth, we propose an eclectic, multidimensional model for intervention built on the foundation of a solid interpersonal relationship between the depressed child or adolescent and the potential helpers in his or her environment: counselors, teachers, and parents. This relationship must incorporate the basic core conditions of empathy, warmth, and genuineness as well as respect for differences. It must also incorporate multicultural awareness and sensitivity. In Esteban's case, multicultural sensitivity involves more than a knowledge of Mexican-American cultural norms and needs to include an awareness of societal influences such as racism, oppression, and economic marginalization and of the effects of these influences on people of color and on their communities. However, this necessary interpersonal relationship is not sufficient for the successful treatment of depression.

Esteban's depression involves a complex pattern of cognitions, behaviors, affect, family dynamics, and larger environmental issues. The nature and severity of his apparent depression should be assessed thoroughly, via a family intake and measures of anxiety, depression, anger, and self-esteem. These factors combine to influence and be influenced by family dynamics, poor school performance, fear of interaction with others, peer rejection, and overt and covert racism that he experiences regularly.

Given the complexity of Esteban's present problems and the threat of future overtly violent behaviors, our multidimensional model indicates the employment of a comprehensive intervention plan. This plan should be responsive to Esteban's degree of risk along the continuum included in the conceptual model for understanding and intervening with at-risk youth (McWhirter et al., 1993) that is presented in the section on approaches to prevention and treatment. Esteban is clearly beyond prevention strategies; but attending directly to his depression involves skill building—which is basic to any prevention program and important for preventing future problems. In Esteban's case, effective intervention should include a behavioral component with both life skills training and activity level increase; a cognitive component designed to identify, test, and modify his dysfunctional beliefs related to himself, his family, his environment, and his future, and to help him monitor self-control; family interventions designed to improve the communication within the family and to improve his mother's consistency; and school interventions designed to attend to Esteban's poor performance, relationships with peers, and poor self-esteem. Finally, some understanding and use of biological and pharmacological interventions may be necessary.

## SUMMARY

Depression is a significant and complicated mental health problem among children and adolescents. Its manifestation in childhood varies, but in adolescence depression is similar to that found in adulthood. It is often linked to other at-risk factors such as suicide, school attrition, and behavior problems, which further augments the difficulty in making appropriate diagnosis and establishing effective treatment interventions. Additional research is clearly needed to gain a better understanding of the frequency and severity of this disorder and of the effectiveness of depression prevention and treatment among children and adolescents.

What is very clear is that depression can have a catastrophic effect on youngsters and on those around them. This is true for young Esteban. The interventions described in this chapter involve the family, individual, school, and community and can be employed in a comprehensive way to help tackle the depression that Esteban—and many other youngsters—experience. Parents, counselors, teachers, and other school personnel who play primary roles in the lives of children and adolescents must be especially aware of and responsive to the symptoms, causes, and problems associated with depression. Recognizing and responding quickly to depression and to its root causes is important in avoiding the potentially devastating effects of this disorder on the young people with whom we live and work.

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# 7 Stress and Coping in Today's Society

*Russell D. Miars*

Multiple and conflicting time demands, social, economic, and political competition, and the complex and ever-changing nature of technology and the world of work characterize the society we live in. As popularized in numerous self-help guides (e.g., Davis, Eshelman, & McKay, 1988; Girdano, Everly, & Dusek, 1990), coping with stress has become synonymous with modern adult life. Interestingly, the image of a carefree childhood devoid of stress has dominated our cultural view of youth for most of this century. Since the mid-1980s, however, there has been an increasing awareness not only that children and adolescents experience stress (Humphrey, 1988; Youngs, 1985) but also that, in complex fashions yet to be understood, the numerous stresses youth actually experience are linked to the alarming rise in at-risk behavioral difficulties many youth display (Gottlieb, 1991). Paradoxically, although youth and adults alike seem to know what it means to be stressed (e.g., being under pressure; being tense or anxious about problems at work, school, or in the family; feeling overwhelmed), there has yet to emerge a uniformly agreed-upon definition of the stress concept by researchers in the stress field. This problem of definition in the literature complicates any discussion of stress and coping in youth. An additional complication is that most stress research has been conducted exclusively with adults (Johnson, 1986). This results in a temptation to extrapolate and apply our understanding of stress and coping in adults to youth (Ryan-Wenger, 1992). It is doubtful, however, that stress and coping in adults is the same, or directly similar, to stress and coping in youth (Johnson, 1986). In fact, several authors (Dise-Lewis, 1988; Humphrey, 1988; Youngs, 1985) are quite clear that stress in youth must be regarded as distinct. Yet the research evidence to support this claim is preliminary and only now beginning to appear in the literature (Aneshensel & Gore, 1991; Colten & Gore, 1991; Ryan-Wenger, 1992; Wertlieb, 1991).

This chapter examines what is currently known about human stress and coping processes in general, giving special attention to the causes and prevention of stress in youth. After a brief review of the predominant ways stress has been conceptualized over the past three decades, the chapter concentrates on the sources of stress in children and adolescents, with consideration of how developmental stages interact with the experience of stress; what is known about the coping strategies used by youth; and the prevention of stress from family, individual, school, and community perspectives.

In this chapter, the term *children* refers to youth preschool to age 10 while *adolescents* refers to youth ages 11 to 19. This is a useful convention (see Peterson, Kennedy, & Sullivan, 1991) because of the key developmental transition from childhood to adolescence broadly represented by the start of the second decade of life at age 10 (with individual variation in the starting of adolescence occurring with the timing of puberty). As used here, the term *youth* is inclusive of preschool to age 19.

## PERSPECTIVES ON THE STRESS CONCEPT

As just noted, researchers and theorists have had difficulty agreeing upon a consistent definition of stress (Johnson, 1986). Historically stress research has focused more on the consequences of stress for organismic functioning (Selye, 1993) than on how stress is aroused (Pearlin, 1993) and subsequently coped with at the emotional and behavioral level (Moos & Schaefer, 1993).

Although acknowledging that a complete and uniform definition of stress has yet to emerge in the literature, Johnson (1986) asserted that stress has been conceptualized from only three major perspectives: stimulus-oriented views, response-oriented views, and stress as a transaction between person and environment.

### Stimulus-Oriented Views

From this perspective, the focus is on stress as a specific stimulus: "...stress is seen as resulting from experiencing any of a number of situations that are noxious or threatening or that place excessive demands on the individual" (Johnson, 1986, p. 16). Research that has defined stress from a life events perspective (e.g., natural disasters, divorce, death in the family) falls under this view. Although useful, particularly when relating stress to the onset of physical disease (e.g., Creed, 1993; Holmes & Rahe, 1967), this perspective alone is significantly limiting in that it cannot account for why some individuals experience potential stressors negatively while others experience the same stressors as a positive challenge (Johnson, 1986).

## Response-Oriented Views

Up until the 1960s stress was almost exclusively defined from a stimulus perspective, meaning the effects of destructive environmental demands (Lazarus, 1993a). Embedded in this framework was an "engineering analogy" of stress in which an external force created a strain on the object and deformed it in proportion to the pressure of the stressor (Lazarus, 1993a, p. 22). After several decades of work around the stress concept, Hans Selye (1974) asserted that stress is the organism's physiological response to external stressors. Selye's (1974) work popularized a physiological version of the engineering analogy by conceiving of stress as having three distinct phases: alarm reaction, resistance, and exhaustion. This sequence was termed the *general adaptation syndrome* (GAS) and referred to the "manifestations of stress in the whole body" (Selye, 1974, p. 139).

In the *alarm reaction* phase, considered to be the most important element of the GAS, the organism responds with a series of complex biochemical alterations. Numerous bodily systems speed up (e.g., breathing, blood sugar release) through the discharge of hormones preparing the body for fight or flight (see Selye, 1993).

Because a state of alarm cannot be maintained continuously, a second phase, the *stage of resistance*, ensues. If the stressor continues to impinge on the organism, its limited adaptational energy is focused more singularly on resisting further the threat presented by the stressor. Unfortunately, when the organism's adaptational energy is focused on selected stressors in an ongoing fashion, it leaves itself vulnerable to other ensuing stressors (Ivancevich & Matteson, 1980). This "biological stress syndrome" (Selye, 1974) is how numerous stress studies have successfully linked various stressors with the onset of psychiatric (Rabkin, 1993) and somatic disease processes (Creed, 1993; Holmes & Rahe, 1967; Selye, 1993).

The final and third phase of the GAS is the *stage of exhaustion*. Selye emphasized that the body is limited in adaptability, or the amount of adaptational energy available to withstand stress. Once the adaptational energy has been expended, significant efforts at restoration must follow, and even then there is some wear and tear (Selye, 1993) on the body's total reserve of adaptational energy. If the body cannot engage in replenishment and restore itself to the level of resistance, a phase of burnout (Pines, 1993) may ensue. Most adults have had some experience with burnout in terms of their involvement with work, career, or other prolonged life stress events. We tend to forget, however, that because of the incredible energy that youngsters expend in multiple spheres of activity, they too, by their very developmental nature, are equally vulnerable to burnout (Youngs, 1985).

Two limitations of the response-oriented perspective are that some individuals do not show the stressful response even in the face of a presumably stressful stimulus, and that a stressful stimulus cannot be specified independent of a person's stressful response to it (Johnson, 1986).

## Stress as a Transaction Between Person and Environment

Because of the limitations of the stimulus-oriented and response-oriented views, an additional model has emerged in the literature that incorporates many aspects of the stimulus and response perspectives but also takes into account the interaction between the person and the environment in accounting for stress and coping. This view has been most fully developed by Lazarus (see Lazarus & Folkman, 1984). Of critical significance from this perspective is how the person views (appraises) the stressfulness of the environmental event (e.g., whether the event is seen as threatening or nonthreatening, desirable or undesirable, controllable or uncontrollable), and how readily available the person believes coping resources are for dealing with the events. Out of this perspective Lazarus and Folkman (1984, p. 19) offered their definition of stress: "Psychological stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being." The emphasis in this definition is on the psychological processes (cognitive and mediational variables) in the person's experience of stress. As Lazarus has developed his theory from the mid-1960s to the present, he has argued that stress should be seen as a subset of emotion (Lazarus, 1993a). This view is adopted for two reasons: first, knowing that a person is experiencing "emotions resulting from harms, losses, and threats" (e.g., anger, anxiety, fear) or from "emotions resulting from benefits" (e.g., joy, pride) in response to stress is very useful and says a lot more about how a troubled "person-environment" relationship is being coped with than when the subjective experience of emotion is omitted (p. 24). As Houston (1987) noted, "...an event cannot be regarded as a stressor without reference to the affective response it elicits" (p. 379). Second, the more striking issue in understanding stress is the person's various coping responses to stressors, not just the body's physiological response and adaptation to stress.

Although it is beyond the scope of this chapter to present a full theoretical discussion of Lazarus's theoretical model (see Lazarus, 1991, 1993b; Lazarus & Folkman, 1984), it is useful to highlight here that a significant portion of stress research has shifted from an emphasis on the physiological response aspects of stress (although that is an inseparable aspect of stress; see Arnold, 1990b), to examining the psychological experience of stress and the ways in which the organism copes with or buffers (is resilient to) stress (Houston, 1987; Lazarus, 1993b). This is particularly true of research on stress and coping in youth.

## CAUSAL FACTORS

Exact causal factors relating stress to certain emotional or behavioral outcomes are exceedingly difficult to show in the stress field, and researchers may never be able to make many exact causal inferences from the available data (Johnson, 1986). Part of the difficulty is that it is now known that the experience of stress is multiply determined by personality characteristics and contextual factors (Peterson et al., 1991) and compounded even further by a large range of individual response variation around any one given source of stress (Lazarus, 1991, 1993a). This is particularly true for children and adolescents as developmental age changes interact with stressors to produce varied outcomes in coping responses (Compas & Phares, 1991). Thus the identified sources of stress highlighted in this section do not prove a causal relationship between the identified source and a stress outcome, especially when applied to an individual case.

Because whole volumes have been compiled on current research and theory on stress and coping in youth, what follows are selected highlights of what is currently known about the sources of stress in childhood and adolescence. For more complete presentations on these topics, several excellent sources are available, including Arnold (1990a), Colten and Gore (1991), Goldberger and Breznitz (1993), and Humphrey (1988).

### Life Event Stressors

Life event scales have been developed for children (Coddington, 1972) similar to those originally developed for adults (Holmes & Rahe, 1967). The key feature of these scales is that they index *the source* and the *amount of change* demanded by the occurrence of specific events across the developmental age range of youth. For example, the death of a parent is regarded uniformly as a very major life change (and stress) across preschool, elementary, junior, and senior high, whereas change to a different school is regarded as a minor change for preschoolers and progresses to a moderately challenging change for high school students (Johnson, 1986). Each stress event has its own rated level of life change units that varies across the preschool to senior high age range. There are 41 life events listed in Coddington's (1972) scale, including divorce or remarriage of parents, increase in arguments between parents, arguments with parents, and death of brother or sister (see Johnson, 1986, p. 34, for the complete list).

Two problems arise with the life events approach to the causes of stress in children and adolescents. One is that the external view of raters such as parents, teachers, and other adults is questionable in terms of whether the ratings actually correspond well with children's self-ratings of the same events (Johnson, 1986). The other is that life events are regarded as stressful (i.e., negative) without consideration of their desirability (e.g., getting married). An alternative approach for addressing these issues, and one that may be more useful in practice settings, is to ask the child to indicate events as either *good* or *bad* and then provide self-ratings of the extent of impact of the event (e.g., *none* to *great*) in the child's life (Life Events Checklist; Johnson, 1986). The child or adolescent's evaluation and subjective perspective is thus preserved and may be a more valid indicator of childhood stress. Johnson (1986) summarized a number of studies that show that child/adolescent adjustment and life stress scores using either measurement approach have shown a significant relationship between increased levels of life stress and difficulties with self-esteem, delinquent behavior, poor school performance, and overall level of psychiatric symptomatology (including such specific psychological problems as suicidal tendencies and anorexia nervosa). The implication of these studies was that the accumulation of unchecked stressful life events may set the stage for vulnerability to, and possible development of, at-risk emotional (e.g., depression) and behavioral (e.g., conduct disorder) problems in youth.

## Daily Stress

Another source of stress that has been identified over and beyond the occurrence of specific life events is the stress-inducing potential of mundane, chronic daily events or what has been called *daily hassles* (Vingerhoets & Marcelissen, 1988). In adults, DeLongis, Coyne, Dakoff, Folkman, and Lazarus (1982) have shown that not only do daily hassles have the potential to induce stress, but they may also play an even stronger role in a person's physical health status than traditional life event stressors.

With respect to children, Youngs (1985) has suggested that the abundance of choices in modern society (especially in urban environments) and the increased cultural emphasis placed on self-fulfillment create a chronic underlying current of stress in children. In the adolescent years a similar stress may exist stemming from so many choices around forming interpersonal relationships (Compas & Wagner, 1991) and pursuing career/vocational options (Youngs, 1985). In both these arenas, however, choice also means the stress of relinquishment: not all desired peer relationships are possible, and career/vocational aspirations may be frustrated by today's economic environment of low growth and diminishing expectations in the rapidly changing world of work (Zunker, 1994).

## Home and Family Stress

Home and family are important contexts for understanding stress in children and adolescents and represent a large portion of the types of stressors youth experience (Humphrey, 1988). Numerous studies have identified significant relationships between the extent of parental stress and levels of child distress (Compas & Phares, 1991). Most, but not all, of these studies have shown that as one or both parents' stress and maladjustment increase so does the level of stress and maladjustment in the child or adolescent. Discussions of child abuse, divorce and marital dissolution, family economic problems, and adolescent-parent conflict illustrate how home and family stress can be strong sources of stress for many youth.

***Child abuse.*** Physical, sexual, emotional, and negligent abuse of children is of enormous concern in our society, and in spite of the increased effort to combat child abuse over the past half century, the true incidence and damaging consequences of abuse are still not fully known or understood (Johnson & Cohn, 1990). Relevant for this discussion is that parental stress is considered to be the major cause of child abuse (Straus, 1980), with child abuse being a major family stressor in the lives of those youth who are abused. Typically, the stress the child or adolescent experiences from the abuse is not expressed as such, but rather through a wide range of emotional and behavior difficulties such as anger, apathy, delinquency (Widom, 1991), school problems, shame, and eating disorders (see Johnson & Cohn, 1990, p. 271, for a comprehensive list of reported effects). Interestingly, the typical runaway is likely to have come from an abusive family and may regard life on the street as less stressful than the home environment (Farber, Kinast, McCoard, & Falkner, 1984). This is just one example of how the ongoing effects of the stress of child abuse can be displaced in the form of other at-risk coping strategies in youth.

***Divorce and marital dissolution.*** From a life events perspective, parental divorce is ranked second only to death of a parent as the most stressful life event a child or adolescent might experience (Coddington, 1972). Current statistics have indicated that as many as 60% of youth will spend a portion of childhood or adolescence in a single-parent situation (Norton & Glick, 1986). In recent years researchers have expanded their concern about the effects of divorce from a more singular life event readjustment to the chronic effects of divorce on children's mental, emotional, social, and academic development (Kalter, 1987; Wertlieb, 1991). The antecedents (emotional conflict and diminished support) and aftermath (divorce wars) of divorce are now considered as more inclusive aspects of the actual stress youth experience from marital dissolution (Arnold & Carnahan, 1990). Arnold and Carnahan (1990) summarized a number of studies that showed an interaction between sex, age, time of divorce in the youth's life, and the stress of readjustment. In general boys appear to experience the stress of divorce more intensely at the elementary level while girls at this age fare about as well as those in intact families. Later, however, adolescent girls of divorcing parents show significantly increasing problems with self-esteem and, later still, in heterosexual relationships. Overall, one of the better ways to understand divorce as a source of stress for youth is to recognize the significant loss/change in access to parents the experience usually represents (Arnold & Carnahan, 1990). Diminished access to parents can significantly reduce the felt social support youth receive from parents at times when they may critically need it (e.g., around the stress of school). As noted further in the section on prevention approaches, for a variety of life event and chronic stressors, social support plays a critical role in buffering the negative effects of stress (Gottlieb & Wagner, 1991).

***Economic stress.*** No discussion of home and family stress is complete without mentioning the chronic and often devastating effects of economic stress in the family (Committee for Economic Development, 1991). Poverty creates an overall psychological environment in the family that is stressful for parents and youth alike, and is linked to the incidence of numerous mental health adjustment issues of children (e.g., child abuse and its associated stresses). But economic stress is not limited to those families struggling to make ends meet. Occupational stress in adults has been associated with a number of health and psychological adjustment variables (see Holt, 1993), contributing to the overall level of stress in the family. The dual roles of career and parent, especially for women but increasingly for men as well (Zunker, 1994), create stress in the form of daily hassles (e.g., child-care arrangements) and strain in the parenting role. Finally, job loss, career change, and being a displaced worker are all stresses deriving from economic change/uncertainty and the stress inherent in the rapid change to a technology and service-based economy (Zunker, 1994). Whether directly through financial strain or indirectly through parent job/career stress, economic stressors are a significant source of stress for today's youth.

## School Stress

All aspects of the school experience challenge youth to adapt to the stresses of the educative process. Sears and Milburn (1990) listed 25 common school-age stressors. These include anxiety about going to school, changing schools, competitiveness (including fear of failure and fear of success), conflict with teacher, failing an exam, worrying about taking tests, and peer teasing (p. 225).

Paradoxically, although for some youth school is a major source of stress, for others school can be a source of motivational challenge and stress relief (Elias, 1989). Thus when assessing the stress experienced by a child or adolescent, the nature and impact of the stress can only be ascertained in the context of the child's whole life space—background, home life, school life, age, and sex (Humphrey, 1988).

For many youth, and possibly increasing numbers of youth, the school experience is not the benign academic learning experience it was once regarded to be (Elias, 1989). School reform pressures, which overemphasize academic success at the expense of psychosocial learning/development, may be contributing to "debilitating student stress" in up to 30% of the student population (Elias, 1989, p. 394). Rather than providing a balance between academics and preparation of students for adult citizenship, social competence, and the world of work, Elias (1989) asserted that schools are under tremendous pressure from parents who are "looking to the schools to guarantee their children's future success" (p. 395). As this singular pressure for academic success and test score performance has increased, so has the stress level of students, to the point that for some the stress is debilitating. Students display the effects of this debilitating stress through physical symptoms of fatigue, headaches, and nausea; a sense of alienation from satisfaction gained through effectiveness and success; and delinquent and antisocial behavior (e.g., substance abuse, gang involvement) as a means of coping with the stress of thwarted expectations for a positive future (Elias, 1989). Elias' (1989) recommendations for addressing the pervasive and debilitating effects of school stress are included in the section on approaches to prevention.

## Developmental Stress

The biological, cognitive, and emotional changes in youth from childhood to adolescence are complex and numerous. They also interact with the perception of and response to other life stress (Peterson et al., 1991; Trad & Greenblatt, 1990). Some of these additional as well as interactive sources of stress in youth—biological, cognitive-emotional, gender, and interpersonal—are briefly discussed here. (For a comprehensive review of the literature on these complex interactions, see Arnold, 1990a, 1990b, and Colten & Gore, 1991).

***Biological changes.*** Puberty is the most dramatic of all the developmental transitions in the human life span (Peterson et al., 1991). Biological changes in early adolescence leading to adult appearance and size, reproductive capacity, and internal endocrine changes produce challenges and stresses in the intrapersonal and social adaptation spheres of adolescent functioning. Issues of sexuality and sexual behavior emerge as a result of these biological changes and are often very stressful for early adolescents and their parents. Further, sex has become an issue for more young people at an earlier age than in previous generations (Youngs, 1985). This observation supports the belief that there is a downward age trend for today's youth in the timing of the stress of sexuality.

***Cognitive-emotional changes.*** The increase in cognitive and emotional complexity required for expanding from a concrete and certain experience of the world to a capacity for abstract and relativistic thinking and emotion (Piaget & Inhelder, 1969) is a developmental stressor of enormous implications in the transition from childhood to adolescence. Larson and Asmussen (1991) reported data that show there is an increase in the experience of negative emotion (anger, worry, hurt) from preadolescence to adolescence. In a certain sense, maturing cognitive and emotional capacities set the stage for adolescence to be the first major confrontation with the existential issues of choice, responsibility, and freedom in the life-span (see Bugental, 1981). As is commonly recognized, the inherent stress of this developmental transition can be overwhelming for many youth. What is less commonly recognized is the adolescent's critical need for parent and peer support (Peterson & Ebata, 1987) as a means of navigating through this challenging transitional period of life.

***Gender differences.*** Gender socialization has emerged as a significant variable in the experience of stress in youth (Gore & Colten, 1991). Some of the conclusions emerging from the literature in this area are extremely relevant to our understanding of the sources of stress in youth, particularly in older adolescents. For example, Peterson et al. (1991) concluded from a number of studies that although in early adolescence there is only one gender divergence (for body image, with girls showing a decline), by late adolescence there is marked gender divergence across all measures of self and negative affect, with girls becoming markedly more depressed as adolescence proceeds. The available evidence suggests that girls "amplify" negative moods as a form of coping with developmental stressors while boys are "more likely to distract themselves from a depressed mood" (p. 105). Thus girls' coping responses to stress change along gender lines during adolescence (suggesting they become more vulnerable to various stressors), but boys' coping responses appear to remain the same. Paradoxically, girls' coping responses to developmental stress in adolescence may set a lifelong pattern of coping with stress through depressive affect. Similarly, the pattern of boys' coping may be protective for gender-based functioning in instrumental and achievement spheres, but it may also be quite maladaptive for future interpersonal relationships requiring emotional intimacy (Peterson et al., 1991).

***Interpersonal stress.*** Interpersonal relationships increasingly become a source of stress for youth as they progress from childhood to early adolescence and through late adolescence. This appears to be true for both girls and boys, but adolescent girls report greater interpersonal stress than boys (Compas & Wagner, 1991). Further, Compas and Wagner (1991) noted that when stressful life events occur in an adolescent's life they are likely to be "*directly* related to others in their social networks, especially their parents" (p. 75). In a study that directly examined adolescent-parent conflict, Smetana, Yau, Restrepo, and Braeges (1991) found that conflict, although stressful, provides a context for debates over the extent of adolescents' developing autonomy, and thus serves an adaptive function. However, when the interaction style between parent and adolescent is negative (i.e., when the interaction is constraining, devaluing, or judging), adolescent development is inhibited (causing further intrapersonal stress and interpersonal conflict). Interestingly, another significant finding was that adolescent-parent conflict is greater in married than divorced families, and that children and adolescents who have had to deal with the stress of parental divorce may actually increase their coping competence and resilience to future life stress (Smetana et al., 1991). Finally, Compas and Wagner (1991) have noted that interpersonal stress shows a reliable developmental variation: in junior high negative family interaction is the predominant source of interpersonal stress, but by senior high conformity and concerns about acceptance by the peer group is the dominant interpersonal stress. Stress arising from dependency on the peer group subsides by later adolescence, and with entry into college, academic events become the predominant source of stress.

## APPROACHES TO PREVENTION

Primary and secondary prevention strategies are both important in reducing stress in youth. *Primary prevention* consists of attempts to minimize youths' vulnerability to stress or actually prevent its occurrence, and *secondary prevention* consists of teaching vulnerable youth therapeutically the coping skills they need to know (Lazarus, 1991).

Because so many stressors of youth (especially in children) are outside their control and related to situations with parents, other family members, teachers, or socioeconomic conditions (Ryan-Wenger, 1992), it is particularly relevant to approach the prevention of stress in youth from a systemic (prior to occurrence) perspective. At the same time, many stressors are unavoidable for youth, or stem from normal developmental challenges. Given this, an additional prevention strategy becomes maximizing the coping resources of youth so that the negative effects of stress are buffered (resisted) to the greatest extent possible (Gottlieb, 1991). This latter strategy reflects the current research emphasis on understanding individual coping processes (Lazarus, 1991, 1993a, 1993b) and psychosocial protective factors (Kimchi & Schaffner, 1990) when the person is under stress. In this overview of approaches to prevention in the family, individual, school, and community, consideration is given to possible systemic prevention of stress as well as various coping and protective factors that appear to buffer the effects of stress in youth.

### Family

From a larger systems perspective, those services that reduce stress in family life can directly prevent the stress in children that can interfere with normal development (Wagner, 1994). Peterson et al. (1991) observed that when such a strategy can be implemented from childhood to early adolescence, and through adolescence, a positive trajectory of coping with the stress of developmental transitions is set in motion. The earlier and the more consistent the support is from parents in this process, the more positive is the overall mental health trajectory of the child. Further, Peterson et al. (1991) noted that positive mental health in children and adolescents (e.g., higher self-esteem) is related to greater internal coping resources (coping style) when youth are faced with unexpected life event stressors (e.g., parent divorce). Given this overall picture, school-based health clinics (Sleek, 1994) that can provide family support (Gottlieb, 1991) in the form of integrated social, health, and mental health services may be one of the most effective means of ameliorating family stress and, by extension, preventing stress in youth.

A more direct way in which the family plays a role in the prevention of stress in youth is through the family's function as an informal social support network (Willis, 1987). Willis (1987) believed the extent to which the family functions as an "informal help-seeking" support system is the extent to which such "informal support may serve to reduce the stressful impact of adverse events" (p. 34). Dimensions of parent/family support that appear to make a real difference in buffering the negative effects of stress are esteem support (e.g., emotional and confidant support), informational support (e.g., problem-solving steps), motivational support (e.g., encouragement), and instrumental support (e.g., material aid such as money). Other family factors that appear to be protective of stress in youth were noted by Kimchi and Schaffner (1990) and included such dimensions as adequate rule setting and structure, family cohesion, lower parental conflicts, open communication, warmth toward the child, and being patient in parenting style. As noted earlier, the family can be a powerful source of stress in youth; likewise, it can be a powerful buffer to stress when functioning effectively.

## Individual

As already noted, secondary prevention of stress consists of teaching therapeutic stress and coping skills to the individual in hopes that the negative effects of stress will not escalate. This may be done in a remedial fashion once stress reduction has been identified to be needed, or more broadly and in advance through coping skills training (Elias, 1989). Because children, and to a certain extent adolescents, are less able to identify the sources of stress or know how to cope with a variety of stressors (Ryan-Wenger, 1992), adults in the lives of youth (teachers, parents) must facilitate the referral of youth for remedial stress reduction and/or anticipate the need for and benefits of coping training (Folkman et al., 1991). Stress reduction strategies and techniques that rely on progressive muscle relaxation, visual imagery, and biofeedback have been shown to be effective for both adults (e.g., Girdano et al., 1990) and children (Humphrey, 1988; Humphrey & Humphrey, 1981; Youngs, 1985). Stress reduction in children might best focus on the aspects of body relaxation, nutrition, and exercise to counter the effects of stress (Humphrey, 1988), while as cognitive development increases, cognitive, emotional, and social support coping skills training are additional forms of preventive intervention for adolescents (Folkman et al., 1991).

With respect to coping, researchers have identified three conceptual frameworks that relate to the present discussion of coping effectiveness in the individual as a preventive measure against stress (see Ebata & Moos, 1991). The first is identified as the *approach/avoidance coping model* (Lazarus & Folkman, 1984) and distinguishes between active approach-oriented coping (toward threat) versus passive or avoidance-oriented (away from threat) coping. Approach coping includes efforts to change ways of thinking about a problem (stressor) as well as behavioral attempts to resolve or address the problem. Avoidant coping includes cognitive attempts to deny or minimize threat and behavioral attempts to avoid or get away from the problem. Research has shown that adolescents who use more approach coping than avoidance coping are better adjusted and less distressed (Ebata & Moos, 1991). Further, Ebata and Moos (1991) concluded that adolescents who show a pattern of avoidance coping may be at greater risk for poorer adjustment to subsequent life stressors and crises. Through coping skills training, adolescents can be shown the positive value of approach coping and encouraged to engage in approach coping behavior when faced with life event and developmental stressors.

A second useful way to think about stress prevention for the individual from a coping perspective is highlighted by the *problem-focused/emotion-focused* distinction (Lazarus, 1993b). In this framework, coping efforts can be focused on modifying the stressor itself (problem-focused) or on attempts to regulate the emotional responses that accompany the stressor (emotion-focused). Ebata and Moos (1991) reported research that suggests that adolescents who use more problem-focused coping with interpersonal stressors (i.e., talking with the other person) report fewer stressful reactions (emotional and behavioral problems) than those who use emotion-focused strategies (i.e., ignored the situation or yelled at the other person). It should be noted, however, that although problem-focused coping is a more effective coping strategy in general, emotion-focused coping may be more effective for certain types of stressors over which the person can exercise no useful action (Lazarus, 1993a).

The third framework for understanding and facilitating positive coping in the individual is related to the role of seeking social support as a coping response. Ebata and Moos (1991) summarized several studies that examined the relationship between family and peer support, active coping strategies, and substance use in adolescents. In general, adolescents who used active behavioral and cognitive coping as well as the seeking of adult support showed less substance use while those adolescents who relied more on peers and acting out to cope showed more substance use (Ebata & Moos, 1991). Other authors (e.g., Gottlieb, 1991; Hendron, 1990) have also noted that attachment, support, and guidance from at least one adult figure (e.g., teacher, coach, parent, school counselor) in an adolescent's life can buffer the effects of stress and facilitate approach and problem-focused coping.

## School

Elias (1989) outlined a number of recommendations that reflect both primary (systemic) and secondary (coping skills) stress prevention strategies in the schools. Basing his perspective on the assumption that school stress does interfere with both academic and social growth in youth, which in turn diminishes the coping resources available to youth, he asserted that "It is...logical and necessary to rethink our view of 'academic time' and incorporate the teaching of coping and learning-to-learn skills into the mainstream of educational programming"(p. 400). From this perspective, he made the following recommendations to reduce school stress:

- *promote accomplishment* by expanding opportunities for children to feel connected to schools as well as feel efficacious in all learning contexts of the school;
- *teach coping skills* and *learning-to-learn* skills as part of the mainstream educational programming;
- adjust the *culture of classrooms and schools* to reflect an integrated approach to social and coping skills development rather than the isolated clinical approach to intervention that is common;
- ensure that schools are *physically safe* as safety is paramount to managing stress;
- increase the value placed on *long-term educational planning* to address complex issues rather than a tendency to seek short-term "program-in-place" solutions that eventually fade;
- use *action-research* as "a procedure in which new programs are tried, monitored, evaluated, refined, and tried again" (p. 402); and
- *shift the emphasis of current training programs* for teachers so that debilitating stress in schools is recognized and addressed through social development education of the child and changes in the learning environment.

As another means of countering the stress adolescents experience in school, Gottlieb (1991) emphasized the benefits of social support interventions. Because inclusion, acceptance, and approval from peer groups are so important in adolescence, peer counseling programs in schools can materially increase the social support adolescents feel. With such added peer/social support, the stressful aspects of school and the challenges of developmental changes can be minimized (buffered).

Further, Humphrey (1988) suggested that stress from academic competition needs to be offset by an increased emphasis on cooperative learning experiences. For example, the stress of math anxiety is centrally based on the way in which math is often taught—in a context of time pressure to finish first, humiliation when being called upon to perform in front of the class, and an emphasis on one right answer (only the end product). All three of these elements are negative and stressful for many youth and reveal a child's weakness rather than his or her competence (Humphrey, 1988). By altering this approach to learning math, teachers can significantly reduce stress in the classroom and produce more confident and capable students.

### Community

Wagner (1994) observed that the povertization of childhood is the single largest threat to the welfare of children today. Clearly poverty is stressful for parents and families and plays a large role in the chronic stress that many youth experience in the family, school, and community. There are no simple or direct ways to prevent poverty, but communities can advocate for changes in public policy that empower children, protect their rights, and facilitate access to social and mental health services to reduce stress (Stern & Newland, 1994). Such efforts when successful can go a long way in preventing stress in youth while benefiting all children as a social group.

The stress associated with violence in the schools can be another important target of community prevention. The threat of violence in schools affects nearly all students, and the fear that results can inhibit a sense of industry, achievement, and self-confidence (Christie & Toomey, 1990). Given that schools are embedded in the larger community, the stress of violence must be prevented by community-based programs. Because it is commonly believed that much of the violence in schools is related to the problems of gangs and drugs in and around schools (in the inner city and suburbs alike), school-community prevention strategies that address these issues (see chapters 12 and 13) reduce an aspect of chronic stress in youth.

In addition, the community can play a preventive role in reducing stress in youth by publicly supporting the continuing efforts of schools to integrate psychosocial education and other intervention at-risk programs into the schools (see Elias, 1989). McWhirter, McWhirter, McWhirter, and McWhirter (1994) identified five Cs of competency that distinguish high- and low-risk youth: Critical school (academic) competencies; Concept of self and self-esteem; Communication with others; Coping ability; and Control—over decision making, delay of gratification, purpose in life. Parents, teachers, clergy, and all adults in the community can help prevent stress in youth by teaching and valuing these coping competencies that are so necessary in dealing with a rapidly changing world.

## SUMMARY

In this chapter stress is discussed from three perspectives: stimulus-oriented view, response-oriented view, and person-environment transaction view. Recent research and theory emphasize the person-environment transactional model in which both the perception of stress and coping responses to stress play an active role in the stress phenomenon. Only since the mid-1980s has research focused specifically on stress and coping in youth. Causal factors for stress in youth are multiple and varied, and are complexly interwoven with the developmental challenges of childhood and adolescence. Life events, daily hassles, family stress, child abuse, divorce, economic factors, school stress, and developmental challenges are highlighted as causal factors for stress in youth. Approaches to prevention are considered across family, individual, school, and community from a larger systems perspective as well as from individual coping skills and social support factors that are preventive of stress in youth.

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# III

# WORKING WITH YOUTH AT RISK: PREVENTION AND INTERVENTION

In Parts One and Two, the topic of youth at risk was introduced and the causes examined. In Part Three, Working With Youth at Risk: Prevention and Intervention, behaviors most often identified as placing youth at risk are addressed. Each chapter in this part of the text introduces and identifies the problem, presents a case study, and describes approaches to prevention, intervention strategies, adaptions for diversity, and a summary. Authors discuss both prevention and intervention from individual, family, school, and community perspectives.

Chapter 8, The Secret and All-Consuming Obsessions: Anorexia and Bulimia, provides introductory material with respect to the impact of the media, gender socialization, and body image on youth at risk for eating disorders. Risk factors such as gender, age, socioeconomic status, family characteristics, and identification with socialized norms are also discussed. Such background information along with a thorough discussion of definitions, symptoms, and etiology create the context for the case study and subsequent presentation of approaches to prevention and intervention.

In the United States, over 1 million, or approximately 11%, adolescent women become pregnant each year. Thousands of infants are raised by children under the age of 14; thousands are the second child born to a 16-year-old mother. Chapter 9, Adolescent Pregnancy and Childbearing: A Focus on Prevention, is based on the assumption that universal remedies are necessary for the successful reduction of adolescent pregnancy and childbearing. Traditional sex education, life management skills training, the impact of the Adolescent

Family Life Act, school-based clinics, community family planning services, residential programs, and life options programs are some of the possibilities discussed in this comprehensive overview.

Chapter 10, Adolescents and AIDS: Education, Compassion, and Acceptance, provides an indispensable resource for those working with this at-risk population. As noted in this chapter, researchers are currently struggling to acquire the information and medical technology needed to develop a cure for HIV/AIDS. The outlook for a cure, however, is not optimistic; some say we must learn to live with some form of HIV as long as there are human beings on this planet. Others say that even with a cure, elements such as poverty, racism, sexism, and homophobia will continue to contribute to the far-reaching consequences of HIV/AIDS. In addition to the introduction, case study, prevention, and intervention material in this chapter, an appendix of national AIDS resources is also provided.

The adolescent at risk for suicide has become an increasing concern for schools and communities throughout the United States. Between 1960 and 1988 the adolescent suicide rate rose by 200% compared to an increase in the general population of approximately 17%. According to some experts, one teenager attempts suicide every 90 seconds, and one completes the act of suicide every 90 minutes. Chapter 11, "I Don't Want to Live": The Adolescent At Risk for Suicidal Behavior, discusses information all professionals and all parents should know if prevention and/or intervention efforts are to succeed. Discussions of ethnic and gender differences, methods, risk factors, precipitants, myths, and profiles provide the groundwork for the subsequent case study, prevention, intervention, and diversity discussions. An adolescent who is suicidal is communicating the fact that he or she is experiencing difficulty with problem solving, self-esteem, managing stress, and expressing feelings. We need to respond in constructive, safe, informed ways when working with this vulnerable adolescent population.

Chapter 12, Tough Enough: Gang Membership, examines the youth gang phenomenon. Robin Hood and his Merry Men are perhaps the most celebrated gang in literature. Not unlike some gangs operating today, Robin Hood's gang was believed to be helpful by some people in the communities in which it operated. Often modern street gangs first present themselves as protectors of the community. Yet Robin Hood's Merry Men carried weapons, and their behavior, even though they robbed from the rich to give to the poor, was illegal under the criminal codes of the era.

Setting the modern youth gang within the context of history and literature, the discussion in chapter 12 includes an examination of views as to why gangs form, risk factors for gang involvement, and statistics that set the stage for understanding gangs and their impact upon society. A case study profiles a young man involved in gangs as a way of understanding the reality of how those factors shape the choices and lives of our youth. The focus then shifts to diversity and gang involvement, prevention approaches, and strategies for intervention.

Research has shown that use of alcohol is associated with 60% of all murders, 40% of all assaults, and 33% of all rapes and child-molestation. In spite of our technologically advanced modern society, America is fighting an age-old problem: drug and alcohol abuse. This is not a problem limited to adults. Significant percentages of youth and adolescents are experimenting with and becoming regular users of chemical substances, particularly tobacco, alcohol, marijuana, inhalants, and cocaine. Chapter 13, Adolescent Substance Abuse: Past, Present, and Future, focuses on why teens turn to drugs, the physiological mechanisms of drug use, and the roles that parents, schools, and the community have in both prevention and intervention.

No Where to Turn: Homeless Youth is the title of chapter 14. At least 1 million families in the United States are homeless, with incidence increasing at a rate of 25% a year. From the most recent statistics available, it is clear that the faces of the homeless have changed drastically since the days of the white, male, alcoholic or "skid row bum." Forty percent of the homeless are families, and 25% are children. Homeless children's differences in appearance, behavior, and ability demand tolerance and flexibility from teachers and school administrators. The purpose of this chapter is to describe homelessness both demographically and more descriptively using a case example. The chapter also discusses preventive measures society must take to avoid the problem of homelessness and offers several interventions to help increase the numbers of homeless youth in the classroom and address their educational needs.

Chapter 15, Understanding and Preventing School Dropout, concludes the book. The problem of school dropout involves many of the personal, family, and social issues discussed in previous chapters. Demographic correlates, early warning signs, underlying causes, two case studies, clinical and systemic approaches to prevention and intervention, and adaption for diversity form the basis for this informative and cutting-edge chapter.

# 8

# The Secret and All-Consuming Obsessions: Anorexia and Bulimia

*Kimberly S. Wright*

The standard for body size and weight is socially determined. It is a cultural phenomenon that demands that the current ideal physique is slim. Countries that commonly experience the threat of famine have virtually no cases of anorexia or bulimia, and obesity is considered desirable (Bruch, 1973). In previous eras in the United States, larger bodies were associated with prosperity, in contrast with current mores that associate thinness with affluence. Obesity is now considered a correlate of the lower class. Continuous images indoctrinate the public with the message that to be considered successful, masterful, and acceptable, one must display a thin physique (Vandereycken, 1993). This image is one that emphasizes self-control and discipline over self-indulgence. For women, this message is especially strong. Since Twiggy reigned as a premier fashion model in the late 1960s, America has promoted a thinner and thinner standard for the female ideal (Garner, Garfinkel, Schwartz, & Thompson, 1980). It is within this context that the current escalation of eating disorders in the United States is occurring.

Among the most powerful transmitters of social standards is the media. According to Garner and Garfinkel (1980), "the potential impact of the media in establishing identificatory role models cannot be overemphasized" (p. 652). Newspapers, television, movies, magazines, and billboards bombard the public with images and messages about appropriate behavior, dress, food, entertainment, appearance, and beliefs. Avoiding the overt and covert messages of society portrayed through the media is virtually impossible. For men, the standards portrayed include fitness, power, and independence. For women, the standards portrayed include thinness, femininity, and beauty.

The female ideal as defined by the culture fluctuates. The power of these fluctuations is revealed by a study (Garner et al., 1980) comparing the weights and measurements of *Playboy* centerfolds and Miss America Pageant contestants from 1959 to 1978. There was a significant decrease in body weight and body measurements for both groups, despite an increase in height. Additionally, the

Miss America Pageant winners were significantly slimmer than the average contestant in the same pageant. This trend also occurred at the same time that the average woman under age 30 was becoming heavier.

The trend toward a slim female ideal is also illustrated by the recent changes in diet advertisements. Between 1973 and 1991, the United States witnessed a consistent increase in television commercials featuring diet products (Wiseman, Gunning, & Gray, 1993). Interestingly, 1,179 different food and diet advertisements appeared in the women's magazines, compared to 10 in the men's magazines. Anderson and DiDomenico (1992) also found that women's magazines contain over 10 times the number of diet advertisements and articles as men's magazines. The inherent double message is that women need to indulge in various foods and that they need to diet in order to avoid weight gain.

Few would argue that men and women are socialized in different ways. The female and male socialization experiences can be viewed as representative of different cultures. Women are socialized to draw their self-esteem from their physical appearance rather than from what they do (Beattie, 1988). For men, self-esteem tends to be more frequently related to success. This discrepancy, combined with the ideal standards for female appearance, increases a woman's vulnerability to eating disorders.

Body image is the perception of one's own shape and size. Women who compare themselves to models or other ideals often distort their own body image negatively. The body is perceived to be inadequate if it fails to meet ideal criteria. It is not unusual to hear women, or even young girls state "I feel so fat," even when their weight is normal. Among women, it is now the norm to diet. Polivy and Herman (1987) found that the majority of women are dissatisfied with their bodies and have dieted, even though it may not be healthy.

Body image distortions are more prevalent among women than among men. In a study of college males, 65% of a sample of 340 reported that they weighed within 5 percentage points of their ideal weight (Franco, Tamburrino, Carroll, & Bernal, 1988), in contrast to the typical body dissatisfaction of their female peers. Women tend to exhibit greater body dissatisfaction and body image distortion than men (Connor-Greene, 1988). Even among men with bulimia, the desired ideal weight has been found to be more realistic than the desired ideal weight of women with bulimia (Schneider & Agras, 1987).

## THE PROBLEM

The prevalence of eating disorders has consistently increased in the United States across the last 30 years. Increasing emphasis on thinness and physical fitness has altered the standard for appearance for women. The *fitness movement* is a misnomer. Individuals flock to gyms and aerobics classes under the guise of cardiovascular health, but in reality they are seeking to achieve the physical ideal of attractiveness. The current trends are not in danger of reversing, which leaves the social climate primed for a continuing increase in eating pathology.

## Risk Factors

***Gender.*** Although anorexia and bulimia are typically characterized as female afflictions, they cross gender lines. Although these disturbances do appear more frequently among females, males can develop either disorder. It is likely that many cases of anorexia or bulimia among males go unreported for several reasons: men are reluctant to admit symptoms of a "female disorder," eating large quantities of food is not considered abnormal by adolescent boys and young men, and clinicians are less likely to explore eating disorder symptoms among males. Even considering the potential underreporting among males, women are at higher risk for developing anorexia or bulimia due to the value placed on their appearance. (The gender differences are reflected by the use of the female pronoun throughout this chapter, unless specifically referring to males.)

***Age.*** Adolescence is a high-risk period for the development of eating disorders, with the most frequent emergence of anorexia and bulimia occurring between the ages 14 and 18. However, atypical onset patterns exist. The developmental tasks of adolescence interact with the physical and social demands of maturation to create a vulnerability to developing eating disorders during adolescence or early adulthood.

Adolescence poses a variety of developmental tasks and social demands: establishing greater autonomy, creating stronger peer attachments, and developing a personal identity. These tasks represent a struggle for all adolescents. When combined with the physical maturation that occurs during this period, the expectations may seem overwhelming. For females, physical maturation can appear incongruent with the tasks of developing peer and romantic relationships because the childishly thin physique is often seen as the ideal for attractiveness.

***Socioeconomic level.*** Women with anorexia and bulimia have most frequently come from the middle to upper-middle socioeconomic class (Anderson & Hay, 1985), and obesity tends to be associated with lower socioeconomic status. This pattern is not consistent, however, especially among youth with upwardly mobile aspirations, such as first-generation college students.

***Family characteristics.*** The families of those with eating disorders are described as chaotic and conflicted in the case of the bulimic (Schwartz, Barrett, & Saba, 1985; Boumann & Yates, 1993) or overcontrolling and rigid in the case of the anorexic (Sargent, Liebman, & Silver, 1985). Although these are simplified, stereotypical portrayals, family problems are common among the eating disordered population. It is also common for another family member to have struggled with weight problems or an eating disorder. A review of research indicates convergent evidence that the families of eating disordered individuals have a higher rate of affective disorders, alcoholism, and conflictual and controlling family relationships (Kog & Vandereycken, 1985).

***Identification with socialized norms.*** In a sample of 682 college students, Mintz and Betz (1988) reported that disordered eating was strongly related to the endorsement of sociocultural norms that regard female thinness and attractiveness as an indication of worth. Those women who hold beliefs similar to the traditional gender expectations are at greater risk for eating disorders.

Although many of the risk factors prominent in eating disorders are featured in other disturbances of youth, such as alcohol and drug abuse or depression, the sociocultural and gender pressures are the distinguishing features of anorexia nervosa and bulimia.

## Anorexia Nervosa: Definitions, Symptoms, and Etiology

The prevalence of anorexia nervosa (typically referred to as anorexia) among the general population is reported to be between 0.5% to 1.0% (American Psychiatric Association [APA], 1994), but it is believed to be higher among high school and college populations (Mintz & Betz, 1988). Approximately 90% of the cases of anorexia nervosa are female. Cases with eating disturbances that do not meet all the criteria for anorexia nervosa are more common. The onset is most likely to occur in adolescence and early adulthood, but cases of earlier and later onset have been reported, with a later onset more common among ethnic minorities (Anderson & Hay, 1985). The reason for the later onset among minorities is as yet unknown.

Anorexia nervosa is a constellation of symptoms in which an extreme drive for thinness, fear of becoming fat, and a restriction of food intake are central. *Anorexia nervosa* is actually a misnomer. Literally translated, anorexia nervosa means "nervous lack of appetite." Although there is a denial of hunger, actual hunger loss does not occur until the very advanced stages of the disorder.

The recently revised diagnostic criteria presented in the *DSM-IV* (APA, 1994, pp. 544–545) allow for greater specificity in diagnosis and highlight the similarity of some symptoms common to both anorexia nervosa and bulimia nervosa (see also Tables 1, 2, and 3). The critical elements of anorexia include:

- refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less that 85% of that expected; or failure to make expected weight gain during periods of growth, leading to body weight less than 85% of that expected);

- intense fear of gaining weight or becoming fat, even though underweight;
- disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight; and
- in postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Further, the *DSM-IV* specifies two types of anorexia:

- *restricting type.* During the current episode of anorexia nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

**Table 1 | Symptoms of Anorexia Nervosa**

**Psychological**
- Perfectionism
- Depression
- Distorted body image
- Intense fear of food and weight gain
- Inflexibility in thought and behavior
- Feelings of guilt about eating
- Denial of problem
- Anxiety
- Thoughts of suicide
- High need for control
- Mood lability
- Poor self-esteem
- Compliance

**Behavioral**
- Extreme food restriction
- Isolation from friends and family
- Fatigue and irritability
- Compulsive exercise
- Vomiting meals
- Abuse of laxatives, diet pills, or diuretics
- Preoccupation with food and eating
- Extreme physical activity
- Eating alone
- Adoption of loose clothing
- High caffeine intake

**Physical**
- Noticeable weight loss—15% or more of total body weight
- Absent or erratic menses
- Exhaustion
- Cardiac disturbances
- Distortion of hunger and satiety
- Lowered metabolism
- Lanugo—growth of fine facial and body hair
- Malnutrition
- Cognitive disturbances
- Electrolyte imbalance
- Hypersensitivity to cold
- Absent or erratic menses

**Table 2 | Symptoms of Bulimia Nervosa**

**Psychological**

Low self-esteem
Depression
Anxiety
Feelings of worthlessness
Overconcern with weight and body image
Feeling out of control
Suicidal thoughts/feelings
High need for approval

**Behavioral**

Cyclical binging and purging
Binging on high calorie foods (carbohydrates/fats)
Increasing time spent on binging/purging
Abuse of laxatives, diet pills, diuretics, or exercise
Abusing alcohol or drugs
Restroom visits after meals
Preoccupation with food and body image
Eating in secret
Hoarding food
Isolation from friends and family
Poor impulse control

**Physical**

Normal weight
Dehydration
Irritability
Fatigue
Swollen neck glands
Cardiac irregularities
Electrolyte imbalance
Occasional burst blood vessel in the eye
Gastrointestinal problems
Esophageal erosion
Tooth decay/gum disease

- *binge-eating/purging type*. During the current episode of anorexia nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Among the first noticeable symptoms of anorexia are a preoccupation with food, particularly a focus on the fat and calorie content of food. The woman with anorexia may begin by restricting herself to a healthy diet or may begin exercising more than usual. The most striking feature is the determination she evidences. As the disorder progresses, she may begin removing herself from social dining situations. She may be too busy to eat lunch with friends or will excuse herself from an invitation by claiming to have already eaten. As her weight begins to drop she may conceal herself with loose fitting clothes or wear warmer clothing than necessary. She may become compulsive with list making, being sure that no free time exists in her schedule. As her work or activities begin to consume all of her day, she may stay up late at night in an effort to burn more calories. As others begin to notice the change in her appearance or behavior, she is likely to become defensive and isolate herself further. She takes any comment regarding her weight loss as a compliment and a sign of success.

**Table 3** | **Distinguishing Features Between Anorexia Nervosa and Bulimia Nervosa**

| **Anorexia** | **Bulimia** |
|---|---|
| Great weight loss | Minor weight fluctuations |
| More introverted | More extroverted |
| Pride in weight and food control | Shame in bulimic behavior |
| Less sexually active | More sexually active |
| Feels in control with food | Feels out of control with food |

As the disorder progresses, her cognitive functions become less sharp, decisions are more difficult, and her obsession with food becomes unrelenting.

Throughout the process, she becomes more and more entrenched in her behavior. She appears rigid, reacts with denial if confronted, and becomes more secretive in her eating rituals. She becomes more depressed and anxious, and mood swings are frequent. Her sense of self-worth becomes intimately linked with her control of food, largely as a mask for her pervasive feeling of ineffectiveness and inadequacy. She strives for extreme achievement and perfection in her endeavors. Her emotional development and social interactions are less mature than that of her peers (see Table 1).

A single etiology of anorexia has yet to be determined. It is currently accepted that the disorder is of a multidimensional nature. Although the anorexic appears to the world to be a perfect child who is a high achiever, is compassionate toward others, and is respectful toward authority, it is believed that personality deficits precede the onset of the illness (Steiger & Houle, 1991). The extreme control exhibited in the young woman with anorexia becomes a compensation for poor coping skills and feelings of instability (Bruch, 1973).

Psychoanalytic theory postulates that anorexia serves as a defense against maturation. Fears about becoming a woman and developing sexually inspire attempts to control the body. The maintenance of a child-like physique is seen as an unconscious strategy to forestall adult relationships and sexuality. Developmentalists view anorexia as an adaptive tool used to combat great anxiety about developmental crises, such as increased expectations and responsibilities. Sociocultural theorists claim that it is the striving for perfection in appearance as a visible hallmark of success that motivates the woman with anorexia. Learning theory is related to this sociocultural explanation in that initial weight loss is met with praise and positive reinforcement. As she becomes emaciated, the attention received from others turns to concern, which may be positively reinforcing as well. Internal reinforcement operates simultaneously as the anorexic prides herself on her self-control. The control issue escalates as she resists others' attempts to feed her and refuses external intervention. Negative reinforcement maintains the pattern as the fears of food and fat provide the incentive for the avoidance of food. Family theorists hypothesize that the behavior is a means of gaining control and independence from a critical and overcontrolling parent. Food and the body become the areas in which the anorexic can exert control. It is most reasonable to propose a multietiological perspective that incorporates several theoretical considerations while recognizing that no single etiological course can apply to each case.

## Bulimia Nervosa: Definitions, Symptoms, and Etiology

Prevalence estimates for bulimia nervosa vary from 1% to 3% for women and 0.3% for men (APA, 1994) to between 11% and 13% in college populations (Coric & Murstein, 1993; Gray & Ford, 1985). Despite these considerable statistics, a great number of people exhibit bulimic symptoms without meeting the complete diagnostic criteria. As with anorexia, the typical onset of bulimia nervosa is during adolescence and early adulthood.

Bulimia nervosa (commonly known as bulimia) is a disorder characterized by cyclical periods of binge eating, typically followed by purging behavior (vomiting, laxative use, diuretic use, or exercising). The latest diagnostic criteria (APA, 1994, pp. 549–550) have specified two types of bulimia, although in practice the occasional overlap of symptoms make the distinctions less clear. The diagnostic criteria for bulimia nervosa are

- recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - —eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances; and
  - —a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control how much one is eating).
- recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise;
- the binge eating and inappropriate compensatory behavior both occur, on average, at least twice a week for 3 months;
- self-evaluation is unduly influenced by body shape and weight; and
- the disturbance does not occur exclusively during episodes of anorexia nervosa.

Further, the *DSM-IV* specifies two types of bulimia nervosa:

- *purging type.* During the current episode of bulimia nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

- *nonpurging type*. During the current episode of bulimia nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Perhaps the first identifiable symptom of bulimia is an occasional binge-eating episode. The episode may be in response to feeling a need to nurture oneself with food, or to indulge oneself following a period of dieting or restricted food intake. The reinforcement of the binge (feeling soothed, reduced anxiety) leads to repeated binges. The fear of weight gain is often the impetus for later purging behavior, but the purge can also be an accidental discovery (as when spontaneous vomiting following a large meal affords physical relief). As with addictive behaviors, the cycle escalates from an occasional episode to a daily habit.

Binges most commonly occur in the late afternoon or late evening, often after a day of food restriction, but may begin in the early morning. It is not unusual for binging to occur on a daily basis, and for normal meals during the day to be vomited as well. Binges are frequently planned, and time alone must be negotiated. Social activities become limited as activities are scheduled with binging and purging episodes in mind. The woman with bulimia may withdraw most noticeably from meals at which she could be observed, and she becomes very anxious if prevented from purging (either by interruption or situational factors). Mood swings are common. As the disorder progresses, the bulimic's body image becomes more distorted, and her sense of being out of control is less tolerable. As she puts more effort into controlling her food intake, she increases her sense of deprivation and sets the scenario for future binges.

Increasingly, the binge/purge cycle becomes a means of managing all painful emotions, and her awareness of her feelings becomes muted. Although her weight is likely to remain stable, fluctuating within 5 pounds, she begins to look less physically well. Her face and neck may appear swollen, and she may develop a burst blood vessel in the eye from the force of vomiting (see Table 2).

The woman with bulimia is susceptible to depression and has low self-esteem and poor impulse control. She may abuse drugs or alcohol in the way that she abuses food. Her body image is invariably distorted, and she is highly self-critical. She may define herself as a people pleaser and be fearful of confrontation, conflict, or anger. Frequently she identifies feeling lonely, despite the fact that her isolation is typically self-imposed.

The etiology of bulimia is not agreed upon, and it appears that there may be many avenues to onset. Some women develop bulimic symptoms following a diet. A transition or move may trigger bulimic behavior or intensify existing symptoms. Losses (such as deaths, parental separations) are particularly painful and difficult for the bulimic to manage (Armstrong & Roth, 1989).

Increasingly, the etiology of bulimia nervosa is being viewed as multidimensional. A risk factor model has been proposed that posits an interaction between biological, family, developmental, personality, and sociocultural factors (Johnson, Tobin, & Steinberg, 1989). The biological factor most implicated is the correlation between bulimia and affective disorders, particularly depression. The affective instability typically appears prior to the onset of bulimia and suggests a biological vulnerability to bulimic symptoms. Although the disorder may begin with restrictive dieting, the biological urge for food preempts a binge episode. This cycle is maintained by the physical need for food and the soothing emotional benefits of the binge (Lacey, Coker, & Birtchnell, 1986).

Research has supported the position of family theorists that eating disorders are a response or adaptation to coping with a dysfunctional family (Lundholm & Waters, 1991). The family factors that tend to be related to bulimia include a family environment that is chaotic, conflicted, and neglectful, resulting in children who feel insecure, anxious, and disorganized. The inability of the bulimic to identify internal states is seen as a developmental deficit resulting from the parent's inability to respond to the child in a manner that allowed the child to internalize her own awareness. Contributing personality factors are low self-esteem, feelings of ineffectiveness, sensitivity to rejection, and compliance with others. They have persistent shame and guilt about not meeting their idealized goals. Sociocultural factors include the changing gender roles in the dominant culture, the increased pressure for thinness, and the use of the pursuit of thinness as a means of adaptation and social acceptability.

## CASE STUDY: THE STORY OF CARRIE

Carrie is a 19-year-old female of White/Latina heritage. She is in the second semester of her freshman year at a large university. She originally sought counseling to deal with her increasing sense of depression. During her first session with the psychologist, she presented as bright and cheerful, in contrast to her reported feelings of sadness and hopelessness. She was immaculately groomed, of normal weight, and casually dressed.

As Carrie described her current situation, her pain was evident even as she smiled through the tears she fought to keep from falling. She just didn't understand why she couldn't control herself. She had been binging and purging since her junior year of high school and was feeling increasing shame and powerlessness. Although there had been periods when she binged and purged less often (such as during the football season when she was busy with cheerleading and had less time alone), the transition to college escalated the pattern from occasionally to daily. She was also now taking laxatives several times a week and often went for an entire day without eating in order to pay for having binged the day before. This eventually led to another late night binge, which she vomited, and the cycle began again. However, even these efforts in conjunction with 2 hours of daily aerobic exercise did little to conquer her intense fear that she would gain an enormous amount of weight.

She had begun by self-inducing vomiting when she had overeaten or had been drinking alcohol. She had been an unpopular child, and once she had made the cheerleading squad in high school she feared that she would gain weight and lose her new-found social status. She lived in terror that she would be discovered to be as inadequate as she felt.

She described her parents as perfect and her younger sister as the baby of the family. Mom was a perfectionist who was hardworking and demanded the same from her oldest daughter. Dad worked long hours and was not as involved with the family. Carrie did not mention until a later session that her mother was generally quite critical, especially of Carrie's appearance, and had very high expectations, or that her dad drank frequently on the occasions when he was home with the family.

During the first session Carrie described the painful pattern of her daily life:

*Carrie:* I just can't seem to control anything. It feels like this is never going to end.

*Dr. W:* That sounds pretty hopeless.

*Carrie:* It is hopeless. I've been depressed since I first got here. At first I thought it was just homesickness, but everything seems to be falling apart. I can barely get out bed, except to eat, and I can't have another semester with the grades as bad as last semester. Everything seems dark, like there's no escape.

*Dr. W:* Can you tell me what feels so overwhelming?

*Carrie:* Every day feels overwhelming. It starts out with my planning not to eat at all. Because once I start I know it's all over.

*Dr. W:* All over?

*Carrie:* Yeah, I'll start to eat and I won't be able to stop. When I finally realize how much I've eaten, it's too late and my stomach is huge, and I have to get rid of it.

*Dr. W:* It sounds like you aren't aware of your behavior when you're in the middle of a binge.

*Carrie:* I'm not. It's like I just go numb. Then I feel horrible at what I've done and I get sick.

*Dr. W:* Does that mean that you intentionally vomit?

*Carrie:* I don't call it that, but that's the only way I will truly feel better. If I can get rid of it, then maybe I'm not so bad and maybe I don't have to feel too guilty.

*Dr. W:* It doesn't feel like you deserve to eat?

*Carrie:* Not when I can't control myself. And I usually end up eating bad food anyway.

*Dr. W:* Bad food?

*Carrie:* You know, crackers and cookies and ice cream and bread and pizza.

*Dr. W:* And how are those bad?

*Carrie:* Do you know the calorie and fat content of that stuff? I don't allow myself to eat that kind of food.

*Dr. W:* So, the food you don't feel you deserve is the food you end up craving. Can you tell me what happens right before you binge?

*Carrie:* Nothing happens. I just start eating and don't stop.

*Dr. W:* Are you aware of the circumstances or what you are feeling?

*Carrie:* I've never thought about it, but I guess I'm scared and lonely, which I feel all the time.

*Dr. W:* How about when you get angry?

*Carrie:* I never get angry, but I cry a lot.

*Dr. W:* Could it be that you know when you're sad or hurt but not when you're angry?

*Carrie:* No, I just don't get angry. Except at myself when I eat a bunch of bad stuff. I get mad when I don't do what I should.

*Dr. W:* When would that be?

*Carrie:* Like when I don't study enough, or call my mom enough, or work out enough, or when I eat too much.

*Dr. W:* Sounds like you're pretty hard on yourself and your expectations are pretty high. I wonder if anyone could expect to live up those expectations? It doesn't seem like you give yourself much room to make mistakes or to be human.

*Carrie:* I'm supposed to be better than that—I shouldn't have to make mistakes.

## APPROACHES TO PREVENTION

### Individual

Approaches to prevention at the individual level are typically identified as educational programming, especially among groups of high-risk individuals, and early detection of symptoms. In the case of Carrie, high-risk factors were prominent. Her low self-esteem was not ameliorated by her acceptance to a popular peer group and her cheerleading status (a high-risk group in itself). In addition, her family situation compounded the self-esteem and depression. Never feeling adequate for her mother's standards, and feeling alienated from her father, left her feeling no sense of safety or acceptance, making her acceptance within her peer group that much more significant.

Programs aimed at high-risk groups might have helped Carrie to identify her problems earlier. A more important task might be to assist young, developing women in maintaining self-esteem through adolescence when their sense of self-esteem is most tenuous. Prevention efforts aimed at the individual also require that friends and family members take an active role in identifying the warning signs and confronting the behavior of the person.

## Family

The role of the family in the prevention of eating disorders is rarely discussed. Although the dysfunctional characteristics of the family with an eating-disordered member have been identified, intervention at the family level is more common than prevention. The family can, however, be significant in deterring the development of these disorders.

Avoiding the dysfunctional dynamics that contribute to eating pathology is prudent for family members. Family environments that foster an eating disorder tend to be overcontrolling, neglectful, and conflictual, but members do not express their feelings. Families should be encouraged to keep communication open, including discussing unpleasant feelings like anger. Farther, parents should be taught to nurture developmental separation, as is appropriate throughout the adolescent years. With each year, the child is learning to take on new levels of independence and responsibility. This task is impeded when the parents are critical or doubtful, or refuse to allow the child the freedom to grow.

The family can also model an acceptance of making mistakes. This includes a tolerance of human mistakes by themselves and their children. Tolerance is also warranted with regard to appearance. Families who place a strong emphasis on appearance (how each member looks) and on appearances (what others think) tend to imbue this value in their children. It is the lack of tolerance with imperfection that characterizes the unrealistically high self-standards of the eating-disordered adolescent. Removing the value of appearance from the family environment also requires a reduced emphasis on food and weight. Even learning to manage such concerns by family activity or exercise is an improvement over the diet-obsessed family.

Tertiary prevention can take the form of early symptom identification. Because pathological eating is so common (Betz & Fitzgerald, 1993; Polivy & Herman, 1987) and eating disorders are difficult to understand, many families do not acknowledge the problem until the illness is in the advanced stages. In their study of 14 European exchange students diagnosed with eating disorders while in the United States, Van den Broucke and Vandereycken (1986) noted that most of the students had evidence of disturbed eating or weight preoccupation prior to their departure from home. These disturbances went ignored by the natural parents and were not identified in the medical examination required before leaving home. These authors recommended early detection of the more obvious risk factors by family members and professionals (doctors, school nurses, and teachers).

Carrie's family could have been most helpful had they identified the dysfunctional family patterns that allowed Carrie's disorder to escalate without acknowledgement. Addressing the family conflicts, critical style, and withdrawal via alcohol could have prevented an extended course of her bulimia.

## School

High school and junior high personnel are in an important position to assist with the prevention and early detection of eating disorders among adolescents. Omizo & Omizo (1992) suggested that a school counselor should be aware of the risk factors and be watchful of those in high-risk groups such as cheerleaders, drill team members, wrestlers, track team members, gymnasts, and those in the performing arts. In addition to the emphasis on weight and appearance, these are highly competitive environments made more stressful by perfectionistic tendencies and the potential for failure.

The first responsibility of the school counselor is recognition of the symptoms of anorexia and bulimia. The counselor should be aware that some students will not admit eating problems or acknowledge their behavior as a problem. Without the student's willingness to participate, treatment is likely to be ineffective.

Although some school counselors may be trained to work with eating-disordered clients, a decision to undertake treatment in a high school setting should be made with caution. Despite the ethical consideration of counseling minors, especially those with serious disorders, the treatment is likely to be more involved than an overextended school counselor could manage.

Due to the setting and frequent contact with groups at high risk for eating disorders, school counselors might most profitably aim their energies toward education and prevention programs. Some programs that have incorporated eating disorder education and evaluation into the school curriculum have been successful in prevention and early detection efforts (Moriarty, Shore, & Maxim, 1990). The impact of such programs may be most significant among at-risk groups (Killen et al., 1993) because most adolescents will not develop an eating disorder. Such programs might have helped Carrie identify her dilemma and recognize that help was available.

## Community

At present, community prevention has occurred primarily through the media by publicizing famous cases of anorexia. Perhaps because anorexia is considered more glamorous than bulimia, less attention has been given to the latter. Actresses and athletes who have struggled with anorexia have been highlighted through news programs and magazine articles. Talk shows have aired episodes that interview eating-disordered individuals with less fame. Television movies have portrayed the consequences of the progression of eating disorders. We have yet to see public service announcements that warn of the dangers of extreme dieting. Given the heavy investment in thinness as the social norm and the profits generated by the diet industry, warnings against dieting are not likely to emerge soon.

The most important community intervention might be to address the larger societal issues. The strong influence of the media on the development and maintenance of eating disorders has led most authors to suggest that a change in the societal norms is necessary (Jasper, 1993; Polivy & Herman, 1987; Ussery & Prentice-Dunn, 1992). Without a reduced emphasis on the value of thinness, prevention efforts will remain primarily early detection devices. The task of shifting societal standards, although seemingly monumental, is central to the prevention effort at the community level. It is unlikely that Carrie would have developed an eating disorder as a means of managing her distress had not the emphasis on women's appearance been so prominent in our culture.

## INTERVENTION STRATEGIES

Given the enormity of the challenge in preventing eating disorders, the majority of theorizing and research has been in the area of intervention and treatment of eating disorders.

### Individual

Individual interventions vary depending upon the theoretical approach used in conceptualization. Psychoanalytic, cognitive-behavioral, developmental, and feminist counselors may approach the treatment of eating disorders in different ways; however, there are some central unifying principles. Regardless of counseling orientation, an initial consideration is the medical stability of the client. Consultation with a physician is essential during the assessment phase. The medical complications arising from anorexia or bulimia are dangerous, and the need to monitor the client's physical condition is imperative.

A medical evaluation of blood pressure, heart rate, and body temperature helps determine the extent of the client's physical danger. Further laboratory tests are necessary to evaluate vulnerable physical conditions: electrolyte levels, estrogen and cholesterol levels, liver and thyroid functioning, and cardiac functioning. Further monitoring by a physician is appropriate when the medical condition of the client warrants close observation, but a medical evaluation should be a component of treatment with all eating-disordered clients as a precaution.

A second consideration is the need for nutritional restabilization. Without adequate nutrition, counseling is less effective due to the cognitive and affective disturbances that result from starvation. For bulimics, as well as anorexics, the quality of the nutritional state is highly compromised as a result of the eating pathology (Story, 1986). For the anorexic, the nutritional goal is a restoration of body weight. For the bulimic, the goal is a restabilization of the nutritional process. Consultation with a nutritionist skilled at nutritional restoration among an eating-disordered population is a useful adjunct to treatment.

Once a therapeutic relationship is built through support and trust, individual counseling can proceed based on the therapeutic orientation. An eclectic approach may be most suited to the multidimensional nature of eating disorders. Treatment should address the behavioral, cognitive, affective, and interpersonal disturbances as they apply to each client. Initial steps in counseling may include helping the client manage affect in more appropriate ways. Learning alternate means of expressing emotions and self-soothing can interrupt the dysfunctional behavioral patterns. By increasing the client's awareness of the distinction between physiological and emotional states, the client becomes more adept at managing denied feelings. Expressing affect, becoming more self-directed and autonomous, and tolerating ambiguity are reasonable goals for counseling. Cognitive interventions are intended to challenge the distorted thought processes that have served to maintain and support the disordered eating. Challenging the irrational beliefs inherent in eating disorder pathology can address issues of body image and self-esteem. Progress in these areas may lead to the exploration of interpersonal and intrapersonal conflicts that plague anorexic and bulimic clients.

When feasible, family counseling can be a powerful component of treatment for the eating-disordered client (Sargent et al., 1985; Schwartz et al., 1985). In addition to addressing the distress created in the family by the eating disorder, family counseling can intervene in any dysfunctional interpersonal relationships. Common issues in these families are enmeshment, overprotection, hostility, and rigidity (Kog & Vandereycken, 1985). The goals of family counseling might include expression of feelings, resolution of conflict, and fostering autonomy.

Group counseling has also been used successfully with eating-disordered clients, although it has been less frequently recommended for anorexics (Lee & Rush, 1986). The use of group counseling in conjunction with individual counseling or for individuals at a more advanced stage of recovery allows clients to reduce the isolation and shame of their disorders. Groups can be effective venues for developing interpersonal skills and challenging dysfunctional thoughts and behaviors. Anorexic clients should be carefully screened for level of rigidity and weight competitiveness prior to admission in a counseling group (Hall, 1985).

Pharmacological treatment, especially for bulimia, has gained favor in recent years (Mitchell, 1988). The use of antidepressant medication has had some success in treating the related depression and in reducing the compulsion to binge. Although controversial, treatments employing a pharmacological component may be a reflection of the current trend toward a biological-based etiology. The use of medication in the treatment of bulimia should be undertaken with caution, and not prior to evaluating the potential risks.

Inpatient treatment is warranted in severe cases. Especially for anorexic clients who have lost 25% of their expected body weight, inpatient treatment is considered necessary. Some bulimic clients, especially those who refuse or are unable to sustain any meals or who have severe depression associated with their disorder, are recommended for inpatient treatment. Individuals with eating disorders may also be referred for inpatient treatment if they have not responded to outpatient treatment. Clients may be admitted by the family if they are under legal age, but it is most therapeutically useful if the client voluntarily agrees to inpatient care.

The structured environment of an inpatient setting often helps to reduce the anxiety of the eating-disordered client. The treatment protocol differs, however, depending on the disorder. The focus for anorexic clients is often weight restoration. For bulimic clients, the focus is on a normalization of the eating process. Both of these strategies are used in combination with individual, group, and family therapy. Close follow-up and extensive outpatient treatment is necessary for these clients due to the high rate of relapse.

Prognosis of eating disorders has been related to type of disorder and body weight. Bulimia has a more positive prognosis than anorexia, and anorexic clients with lower body weights have the poorest prognosis (Herzog et al., 1993). Clinical observation also indicates that anorexia is the more intractable disorder and requires longer term counseling.

## Family

Family therapy is considered by some to be among the most effective treatments for eating disorders and, at the very least, should be considered as an adjunct to other treatment modalities (Schwartz, Barrett, & Saba, 1985). The families of anorexic clients have been described as overcontrolling and rigid (Sargent et al., 1985) while the families of bulimic clients have been described as conflicted and chaotic (Schwartz et al., 1985). Despite these differences, some universal principles in family counseling for eating-disordered clients have been prescribed.

Common issues to be addressed in family counseling often include strengthening boundaries between parents and children, dealing with family and parental conflict in more healthy ways, and openly dealing with other disorders such as depression or alcoholism of another family member (Schwartz et al., 1985). Teaching the family to allow appropriate development of adolescents (which includes allowing less reliance on the parents) is also necessary. Particularly for younger clients, family counseling is considered an important piece of the treatment process.

## School

Although few school counselors are trained in the treatment of eating disorders, it may be the school personnel who first identify disturbed eating patterns.

School personnel should be aware of the eating disorder symptomology and be prepared to encourage youths suspected of such disturbances to seek counseling. Resources and referrals that are available to the students seeking treatment should be current.

Some school settings offer support groups for eating disorders, and this is reasonable if the counselor is skilled in group counseling with eating-disordered clients and treatment consent can be obtained. An assessment of the extent of the student's disorder is prudent prior to beginning any type of intervention at the school level.

### Community

Community interventions are as yet minimal. Perhaps due to the perceived rarity of these disorders, wide-scale community interventions are not practiced. Another possibility for the lack of community-level intervention is the inherent challenge of the societal standard of beauty should such interventions be proposed. Changes at the community level require a concerted effort toward abolishing the value placed on thinness. Currently, the fervor does not appear to exist to orchestrate such a rebellion.

## ADAPTATION FOR DIVERSITY

### Ethnicity

The cultural norms of the United States have historically been dominated by the values of the White middle class. Although the stereotypical picture of the eating disordered client is a young White American adolescent female, the recent increase of anorexia and bulimia among non-White women must be explored (Root, 1990). An important consideration, given the impact of the media on eating disorders, is that few non-White women are featured in the media, and those that do appear tend to have physical characteristics that are similar to the White standard of beauty (Osvold & Sodowsky, 1993). It is as yet unclear what impact these images have on women of color.

A further consideration is that because eating disorders have been related to socioeconomic status, the increasing status of non-White populations in the United States may serve to increase their vulnerability to eating disorders (Anderson & Hay, 1985). Additionally, Hsu (1987) noted that as African Americans become more upwardly mobile they may be more likely to adopt traditional White middle-class values and the related disorders as well. As African Americans more commonly live biculturally, an internalized devaluing of their own race can occur. This can result in greater acceptance of White standards. The typical help-seeking patterns and underutilization of mental health services by people of color may, however, continue to obscure the prevalence of the disorders among these groups (Root, 1990). It has been suggested that the underutilization of mental health services by people of color may be the result of these groups seeking help in alternate ways in their communities or to the lack of experience and understanding of these groups by mental health personnel or poor accessibility to mental health services. Although Dolan (1991) warned against using broad statements about racial groups, the following discussion of cultural considerations attempts to highlight the similarities and differences between cultures with respect to eating disorders.

***African American women.*** Historically, African American women have not been at risk for developing anorexia or bulimia due to several protective factors. They have typically not identified with the standards of the White culture (including the standards for thinness), and they have displayed greater acceptance of their body sizes, despite being heavier than their White peers (Gray, Ford, & Kelly, 1987). Even among the high-risk group of ballet dancers, Black females have reported lower rates of disturbed eating (Hamilton, Brooks-Gunn, & Warren, 1985). Most eating disorders develop during adolescence, and among African-American women this period has been brief by White standards. Eating disorders among this population tend to develop at a later age (Anderson & Hay, 1985). The socialization of many African American women also differs from that of women in the White culture. African American women are expected to be independent and successful, in contrast to the White values for women to be attractive and feminine (Osvold & Sodowsky, 1993). African American women are raised with a more pragmatic attitude and may have little time or energy for food and weight preoccupations.

A survey of 507 male and female undergraduate students at a Black university revealed that 3% of the sample fit the *DSM-IV* criteria for bulimia. When compared to a similar White sample, however, the African American students reported less emphasis on food and weight (Gray et al., 1987).

Silber (1986) suggested that the rarely seen case of anorexia among African Americans and Hispanics may be due more to misdiagnosis than scarcity of the disorder. Although it has been concluded that the symptoms present themselves similarly in Caucasian and African American women (Anderson & Hay, 1985), Osvold and Sodowsky (1993) highlighted the importance of culture in the etiology of anorexia nervosa. Counselors and researchers are urged to be conscious of the later-aged occurrence of anorexia and bulimia among African American women. Additionally, as acculturation to the dominant White culture increases, a higher incidence of eating disorder symptoms among African American women is likely.

***Hispanic women.*** Studies of eating disorders among Latina women are practically nonexistent. One study compared the treatment outcomes of 10 Hispanic women (6 Mexican Americans, 2 Columbians, and 2 Mexicans) and 20 White women with diagnoses of anorexia nervosa in San Diego (Heibert, Felice, Wingard, Munoz, & Ferguson, 1988). No differences between the two groups were reported with regard to clinical characteristics or treatment outcome.

Another study (Smith & Krejci, 1991) with a large male and female high school sample (327 Hispanics, 129 Native Americans, and 89 Whites) found considerable eating pathology among the Hispanic group. On most measures of disturbed eating (fasting, induced vomiting, binging), the Hispanic group scored comparably to the White group, but not as high as the Native American group. The prevalence of eating pathology among Latina women remains illusive. The interaction among ethnicity, social environment, and level of acculturation could be a rich direction for future investigations.

***Native American women.*** Few data are available on the prevalence of eating disorders among Native American women. One study found that among 85 Chippewa girls and women living on a reservation in Michigan, 74% reported dieting in order to lose weight, and of those, the majority had purged, used diet pills, and fasted (Rosen et al., 1988). Although generalizations cannot be made from this sample, the prevalence of eating disorders among Native American women may have been previously underestimated.

A similar conclusion has been drawn by Smith & Krejci (1991). In a comparison of disturbed eating patterns among Native American, Hispanic, and White high school students, the Native American group scored higher than the comparison groups on all measures of disturbed eating. The Native American students were heavier that the comparison group, and students who were heavier reported more body dissatisfaction, greater fear of weight gain, more frequent extreme dieting, and more frequent vomiting as a weight control technique. Further exploration is needed before any reasonable conclusions can be drawn about eating disorders among Native Americans.

***Asian American women.*** Although anorexia is well known in Japan (including a specially named binge episode related to anorexia), studies of eating disorders among Asian American women have not been reported in the literature. Studies of other Asian populations are rare. High rates of body image distortions and body dissatisfaction have been observed among school children and adolescents in Japan (Ohtahara, Ohzeki, Hanaki, Motozumi, & Shiraki, 1993). Case studies have also been reported involving two women of Chinese decent who were raised in England (Schmidt, 1993). The bicultural existence and family histories of obesity are cited as onset and maintenance factors.

Asian American populations have been the least-researched ethnic group. Without adequate data, speculation about the prevalence or course of eating disorders within this population is unwise.

***International women.*** The literature has begun to accumulate evidence suggesting that the risk for eating disorders among international women increases with the level of acculturation of White standards. Assuming a continuum of eating disorder symptomology, Hooper & Garner (1986) compared Black, White, and mixed race schoolgirls in Zimbabwe on eating disorder symptomology. The White group showed the greatest symptomology, the Black group showed the lowest, and the mixed race group had scores that fell between the comparison groups. The researchers concluded that the acculturation and adoption of Western ideals influences the development of eating disorders.

Even Caucasians from different cultures have been susceptible to the influences of American White, middle-class standards. Van den Broucke and Vandereycken (1986) studied 14 European exchange students in the United States who had been diagnosed with an eating disorder during their year-long stay. Most evidenced at least minor eating disorder symptomology prior to departing from home, but the challenges of adolescence combined with the culture shock, separation from family, and the stress of academic and social adjustment served to exacerbate the disorders.

Recommendations for counseling women of color and of nondominant cultures include an awareness of the cultural aspect of the disorders. It is necessary to assess the extent of identification a woman has with her own ethnic culture and that of the dominant White society in addition to the eating disorder diagnostic criteria (Oswold & Sodowsky, 1993), criteria that Root (1990) reminded us were developed from observations of White clients. Mental health professionals should be cognizant of the socially sanctioned stereotypes of women of color and avoid such stereotypes from influencing the assessment process (Root, 1990).

Prevention efforts among ethnicly diverse groups should address the previous lack of prevention involvement in communities of color. Outreach programs can be established with these communities only after allowing for time to build relationships with key leaders and showing genuine interest in the group (Root, 1990). Outreach and prevention programs need to take into account the norms of the community with regard to help-seeking patterns, beliefs about causation and healing, and meaning of the disorder. This strategy might allow for greater inclusion of people of color into research protocols and prevention/treatment programs. (For recommendations regarding inclusion of people of color in empirical studies, see Root, 1990.)

## Gender

Although females have been the most affected by eating disorders, the prevalence among males may be underestimated (Lachenmeyer & Muni-Brander, 1988). Steiger and Hoole (1991) suggested that factors that make women vulnerable also operate to make men vulnerable. One risk factor is that of athletic involvement, especially in sports that have a weight or physical appearance orientation, such as wrestling or body building (Franco et al., 1988). A second risk factor for men is a history of obesity (Franco et al., 1988). Males with bulimia were found to have relatively higher current weights and histories of higher past adolescent and prepubescent weights. A third risk factor for men is homosexuality. It appears that the heterosexual male population is more protected from standards that emphasize physical appearance, but that gay men feel more pressure to be thin or attractive (Schneider & Agras, 1987).

Although men tend to score lower on the Eating Disorders Inventory *drive for thinness* scale and report less body dissatisfaction (Schneider & Agras, 1987), a correlate of the drive for thinness among women may be the drive for fitness among men (Ussery & Prentice-Dunn, 1992).

Ussery and Prentice-Dunn (1992) found that the strongest predictors of bulimia among men were similar to the predictors of bulimia among women: restrained eating, lack of interoceptive awareness, and lack of confidence in identifying one's emotions, which leads to underdeveloped coping skills.

In a comparison of men and women with comparable bulimic histories, Schneider & Agras (1987) found some gender differences. Men with bulimia have been noted to differ from women with bulimia in that they are less likely to identify the intake of large amounts of food as a binge; are less likely to report laxative, diuretic, or diet pill use; and are less likely to exercise excessively. Men also report greater success with diet plans than women. Women tend to binge in private, but male binges tend to occur during mealtimes with larger quantities of food, and they are less likely to report feeling guilty about eating in public.

An exception to the previous discussions of ethnicity is the report of an investigation of bulimia among African American college students, in which Black males were more likely than their Caucasian counterparts to report significantly more frequent binging, dieting, and fasting (Gray et al., 1987).

Men and women may be differentially affected by the cultural pressure for weight and body shape. Social cues that determine appropriate or desired weight hold women to a more stringent standard (Schneider & Agras, 1987). In addition, males with bulimia may go undiagnosed. Men may experience greater embarrassment at acknowledging symptoms that have been characterized as a disorder of adolescent females (Schneider & Agras, 1987).

Although eating disorders occur more rarely in men, and even more rarely in men of color, the disorders do exist in these populations (Gray et al., 1987; Lawlor, Burket, & Hodgin, 1987), and risk factors alone may not alert the clinician. For example, eating disorders have been present in male clients who come from lower socioeconomic groups and do not fit the typical clinical picture. Clinicians should be cautious of dismissing this diagnosis among atypical populations.

## Affectional Orientation

Homosexuality has been reported to be a risk factor for developing eating disorders among men, but not women. Most samples of eating-disordered females report very small percentages of identified lesbians (Herzog, Newman, Yeh, & Warshaw, 1992). For women, homosexuality may offer protection from a vulnerability to eating disorder symptomology. Several factors have been cited as potential explanations for this phenomenon. Unlike heterosexual women, lesbian women are reported to be more satisfied with their bodies (Herzog et al., 1992).

In a study of 64 heterosexual and 45 lesbian unmarried women (Herzog et al., 1992), significantly more heterosexual women wanted to lose weight, despite the fact that the lesbian women among the sample were heavier than the heterosexual women. Both groups chose ideal weights below the appropriate life weight tables (Metropolitan Life Insurance Company, 1983), but lesbian women were more likely to choose higher weights, closer to the norm. The heterosexual women were more likely to diet and were more susceptible to the image society portrays as the female ideal. It may be, as Brown (1987) noted, that feminist ideology rejects the cultural standards of beauty as well as reducing the guilt associated with eating that is found in the majority of the traditional female culture.

Herzog et al. (1992) concluded that the dissatisfaction with one's body that increases the risk of eating disorders among the heterosexual female population is less prominent among the lesbian population and may explain the lower incidence of eating disorders among lesbian women. Caution is warranted, however, in discarding the potential eating disorder diagnosis among lesbians. The incidence of anorexia and bulimia among lesbian women is low, but not absent.

Gay men have been reported to have eating disorder symptomology at higher rates than are found among heterosexual men (Yager, Kurtzman, Landsverk, & Wiesmeier, 1988). Compared to heterosexual men, gay men have been more likely to be underweight, to chose an ideal weight that is lower, and to believe that a thinner body type will be more attractive to potential partners (Herzog, Newman, & Warshaw, 1991). They also reported that heterosexual men were less likely to be influenced by their perceptions of women's preferences for male physique. Their desired weight was less than these men believed women preferred.

When 48 nonclinical gay men were compared to 300 nonclinical heterosexual men, the gay male sample was reported to present past problems with binge eating, use of diuretics, feeling fat despite others' perceptions of them, and feeling terrified of becoming fat. Additionally, gay men scored higher than their heterosexual peers on the EDI scales of drive for thinness, interoceptive awareness, bulimia, body dissatisfaction, ineffectiveness, maturity fears, and the total overall scale.

Findings of higher than expected rates of disordered eating among the gay male population may be related to the tendency toward the effeminate for at least some gay men (Yager et al., 1988). A more reasonable explanation might be that some gay men feel the same pressure that heterosexual women feel to be attractive to males and might be more conscious of the competition for partners. This explanation is further supported by the long tradition among men in general to seek attractive partners. Herzog et al. (1991) noted that gay males may fear weight gain more than heterosexual males because weight gain might surpass their ideal body weight and the weight they believe is most attractive to a partner.

Investigations of eating pathology among the gay/lesbian culture is in preliminary stages, and explanations of the increased prevalence can only be speculative.

## Athletes

Despite anecdotal data, evidence suggests that athletes are not, as a group, at greater risk for developing eating disorders. Certain sport groups do, however, increase the vulnerability for developing eating disorder symptoms (Stoutjesdyk & Jevne, 1993). Among a sample of 191 Canadian athletes, eating disorder prevalence was not higher for females than is found in the general and college populations. The prevalence of disturbed eating patterns for men was, however, higher than has been reported in college and general populations. For women, the risk factors included being involved in a sport that emphasized leanness or physical appearance (such as diving or gymnastics) or that had weight restrictions (such as judo or lightweight rowing). For both men and women, eating disorder symptomology was related to the level of competition. Only those athletes who regularly competed on the national or international level showed elevated scores on a measure of disturbed eating behaviors and attitudes. It was concluded that the combination of high-level competition and weight or aesthetic considerations within the sport makes for a vulnerability to disturbed eating.

Similarly, Depalma et al. (1993) studied 131 lightweight college football players and found that 9.9% fit the criteria for an eating disorder and 42% evidenced disturbed eating patterns. Wrestlers are also at high risk for eating disorder pathology. Steen and Brownell (1990) found that 30 to 40% of high school and college wrestlers reported pathological eating, including food restriction, fasting, vomiting, using laxatives and diuretics, and binging after matches. Preoccupation with weight and food was common among this sample of 431 male wrestlers.

Dancers have also been considered to be at high risk for the development of eating disorders, but this generalization has been challenged. Hamilton, Brooks-Gunn, Warren, and Hamilton (1988) contended that those ballet dancers who are most successful show similar rates of eating disorder pathology as is found in the general population. Those dancers who are struggling to gain recognition in a major dance company, however, are more likely to report eating pathology. This pattern held true for dancers in both American and Chinese ballet companies.

Johnson and Tobin (1991) noted a steady increase in the use of exercise as a purging strategy, especially in recent years as the standard of thinness for women is being replaced with the standard of physical fitness or strength. Given this trend, they warn those involved in the supervision of athletics, such as athletic trainers, to be observant of suspicious behavior. Trainers may be the initial contact for someone struggling with an eating disorder, and they need to be informed and capable of providing a safe environment for the disclosure of psychological problems.

Proposed prevention efforts are aimed at educating athletes and sports management personnel (coaches and trainers) in the dangers of disturbed eating (Grandjean, 1991; Johnson & Tobin, 1991; Thompson & Sherman, 1993). In addition to increasing the awareness of eating disorder symptoms, it is recommended that weight be deemphasized and that group weigh-ins be eliminated. In sports where weight is a determinant for competition, unhealthy weight management strategies should not be condoned, even passively.

## SUMMARY

A clear conclusion is that eating disorders reflect an interaction of social, interpersonal, intrapersonal, and physical variables. The societal ideal for women to be thin and attractive promotes greater pressure for women with regard to appearance and places them at greater risk for developing eating disorders. It is during adolescence or young adulthood that these disorders manifest, usually as a means of coping with problems or life transitions. Other risk factors include socioeconomic status, participation in some types of athletics, disturbed family dynamics, and low self-esteem. Although a small proportion of the population may develop a clinical eating disorder, great numbers of individuals suffer with subclinical symptoms of disturbed eating and dieting patterns.

Treatment may include individual, group, and/or family counseling. A medical evaluation and nutritional counseling are also recommended. In severe cases, inpatient or pharmacological treatment may be warranted. Treating the eating-disordered client requires patience and an understanding of the psychological depth of the disorder. Recovery from an eating disorder is often a slow process, and the relapse rate is high.

Prevention efforts at the individual, family, school, and community levels should be considered by those involved with adolescents or young adults, especially those youths in high-risk groups. Special attention should be paid to atypical groups such as people of color, men, and gay and lesbian youths. These groups are least likely to be identified as at risk for an eating disorder and may be neglected in treatment and research of eating disorders.

The power of society and the media should not be overlooked. It is the responsibility of each individual to challenge the damaging and demeaning messages of our culture. It is equally important to teach our youth to challenge those same messages, whether the messages stem from the media, their peers, their families, or from their own minds.

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# 9

# Adolescent Pregnancy and Childbearing: A Focus on Prevention

*Ardis Sherwood-Hawes and Rosemary A. Thompson*

The incidence of adolescent pregnancy and parenthood in the United States has remained at an alarmingly high level for the past 30 years. During the 1970s, numerous studies indicated that one of the most profound trends among American adolescents was a significant increase in both pregnancy (Dryfoos & Heisler, 1978) and the subsequent rearing of offspring by single, school-age mothers (Ogg, 1976). A study by Ogg (1976) indicated that the number of one-parent families had increased seven times as rapidly as the number of two-parent families, and according to Nye (1976), school-aged children between 14 and 16 years of age represented the most rapidly increasing age group of single parents.

The current statistical reports regarding adolescent pregnancy have remained strikingly similar during the last two decades of the 20th century. Although the size of the adolescent population in the United States has decreased considerably over the past 30 years, the actual numbers on adolescent pregnancy and childbearing have remained fairly consistent (Voydanoff & Donnelly, 1990). Thus each year, a greater percentage of our nation's youth are bearing children before they complete their education or secure their economic future (Patterson, 1990). It is estimated that over 1 million or approximately 11% of United States adolescent women become pregnant each year (Kiselica, Stroud, Stroud, & Rotzien, 1992). The vast majority of these pregnancies are unintended (White & White, 1991), yet over 50% of these pregnancies result in live births. Over 9,000 of these infants are reared by children under the age of 14, and almost 5,000 of these infants are the second child born to 16-year-old mothers (McCullough & Scherman, 1991). Only 5% of the 500,000 infants born each year to American adolescents are placed for adoption, and nearly two thirds of the infants born are reared by single mothers (Cervera, 1993a; Voydanoff & Donnelly, 1990).

The percentages of adolescent pregnancy, abortion, and childbirth in the United States are significantly higher than in other industrialized nations

(Allen-Meares, 1989; Christopher & Roosa, 1990; Meyer, 1991). American adolescents under the age of 15 are five times more likely to give birth than same-age adolescents in comparable countries (Allen-Meares, 1991). Conversely, the rate of sexual activity among United States adolescents is predominately the same as or lower than other analogous nations (Allen-Meares, 1989; Freeman, 1989). (*Sexual activity* denotes initiation of intercourse. Note that studies have rarely investigated alternate expressions of sexual behaviors among adolescents—Furstenberg, Brooks-Gunn, & Chase-Lansdale, 1989).

Although adolescents in Sweden become sexually active at earlier ages than United States adolescents, the United States pregnancy rate is three times higher than that of Sweden (Alan Guttmacher Institute, 1994; Foster, Green, & Smith, 1990). (Noteworthy is that Sweden has the highest, and Canada the lowest, percentage of sexually active adolescents—Foster et al., 1990.) In addition, the United States has the same percentage of sexually active adolescents as the Netherlands but a pregnancy rate six times higher than the Netherlands (Voydanoff & Donnelly, 1990). Most researchers attribute these disturbing statistics to higher levels of consistent and effective use of contraceptives among adolescents in other countries (Christopher & Roosa, 1990).

Sexual activity among adolescents has steadily increased over the past 30 years, and present day adolescents are engaging in sexual intercourse at much younger ages. There are many interrelated social, economic, family, and biological factors that contribute to the current trend in adolescent sexuality patterns (Brewster, Billy, & Grady, 1993; Hofferth, 1991; White & White, 1991). For example, over the past century, young women in industrialized nations have been reaching menarche at younger ages. Menarche, or biological maturity, is caused by the increased production of sex hormones, and this increase is positively correlated with sexual activity (Allen-Meares, 1991; Voydanoff & Donnelly, 1990). Although the average age of menarche is currently slightly over 12 years, the number of children who reach biological maturity at age 9 or younger is rising. These young adolescents may be biologically equipped to produce children, but they rarely have the developmental maturity to cope with their emerging and often bewildering sexual urges, or to understand and prevent pregnancy (Patterson, 1990).

Concurrently, societal changes have overtly and covertly impacted the sexual behavior of young people. Contemporary adolescents experience much more social freedom than did adolescents in the first half of the 20th century. Television, automobiles, telephones, computers, and changes in family structure all contribute to the increased autonomy of today's young people. Families are typically smaller and no longer include extended family members, such as grandparents or other relatives. Children often live in single-parent families, and opportunity for adult supervision is reduced. Even in two-parent households, both parents typically work outside the home, and children have greater spans of time for unsupervised activity with their own peers. When adolescents have expanded periods of unsupervised free time, they become more susceptible to peer pressure and have increased opportunities to experiment with drugs, alcohol, and sexual activity. Research suggests that sexual intercourse among adolescents is more likely to occur in homes with little or no adult supervision (McCullough & Scherman, 1991).

In addition, contemporary children have more exposure to external influences that shape the formation of their value systems. Mass media messages have a powerful impact on the belief systems of young people, and in recent years, media messages have consistently indicated that social attitudes are more permissive toward the expression of sexuality through premarital sexual activity. Our culture condones explicit sexual themes in advertising, the entertainment industry, and all forms of mass media, and these sexual messages convey information to our nation's young about societal expectations toward the development of gender roles, sexuality, and male and female relationships. Conversely, as we bombard our children with confusing sexual images and messages, our culture often denies realistic and complete sexuality information to our young people. Unfortunately, these skewed messages may be the primary source of sexual education for our children. Thus adolescents may be engaging in sexual activity at younger ages not only because of earlier physical maturation and the accompanying sexual feelings, but also because of permissive societal attitudes regarding premarital sexual intercourse, media messages that promote and glamorize sexuality, unsupervised free time, and inadequate training on issues related to sexuality (Croft & Asmussen, 1992; Furstenberg et al., 1989; Plotnick, 1993).

Although young people are becoming physically mature and progenitive at younger ages, they may lack the capacity or maturity to prevent pregnancy or protect themselves from sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV), the precursor of acquired immune deficiency syndrome (AIDS) (Patterson, 1990). At present, adolescents are the population considered to be most vulnerable to HIV, and everyday, due to spontaneous unprotected sexual activity, many of our nation's young people are being exposed to, and possibly contracting HIV (Allen-Meares, 1991; Barth, Fetro, Leland, & Volkan, 1992; Cervera, 1993b).

Many professionals attribute the failure of the United States culture to address issues of adolescent pregnancy adequately and prevent childbearing during adolescence effectively to a lack of specific definition of the problem. Should the primary focus of programs be on abstinence, or should pregnancy be prevented through the promotion of effective and regular use of contraception? The outcome of the solutions designed to reduce the rate of adolescent pregnancy depends on how our society defines the problem of adolescent childbearing (Croft & Asmussen, 1992).

## PROBLEM DEFINITION

An enormous amount of research has been conducted to identify factors associated with rates of adolescent sexual activity, pregnancy, and childbirth. The majority of this research has investigated the characteristics of adolescent mothers to determine what type of female child is most likely to become pregnant and the childbearing consequences for young mothers (Brooks-Gunn & Furstenberg, 1989; Christmon, 1990; Dearden, Hale, & Alvarez, 1992; Freeman, 1989; Meyer, 1991; Watson & Kelly, 1988). This research, which predominately focuses on unmarried adolescents, seems to infer that adolescent pregnancy is acceptable if the female is married.

The cultural bias that places the responsibility of fertility control on the female has led to a dearth of investigative reports on adolescent fatherhood, and even less research on the immediate and long-term consequences for infants born to adolescent parents (Brooks-Gunn & Furstenberg, 1989; Meyer, 1991). Recent studies on adolescent fathers revealed that male and female adolescents who are at risk for early parenthood share many of the same characteristics. Therefore, this chapter predominately uses a gender-neutral approach for the discussion of variables related to adolescent pregnancy and childbearing.

Research has connected adolescent pregnancy and parenthood to a complex and interrelated combination of factors based on culture, economy, family, education, environment, and human development and behavior (Brewster et al., 1993; Hofferth, 1991; Kiselica et al., 1992). For example, a well-developed body of literature has demonstrated that use of chemical substances and early school withdrawal are substantially conjoined with premature initiation of unprotected sexual behavior (Allen-Meares, 1991; Brooks-Gunn & Furstenberg, 1989). This empirical research suggested that use of drugs and alcohol is strongly indicative of future detrimental behavior. However, these studies do not clearly demonstrate whether chemical usage is a cause of deleterious conduct, or an identifier of underlying issues that predispose at-risk behaviors in adolescence (Bayatpour, Wells, & Holford, 1992). Many professionals maintain that chemical substance use is a response to a combination of factors, none of which is causative. Perhaps adolescents, in part, use substances to cope with debilitating emotions (e.g., rage, depression) that emanate due to life stressors or previous traumatic occurrences (Adger, 1991).

When considering the link between noncompletion of education and alcohol abuse, professionals might ask Does alcohol abuse cause declines in academic performance or do students begin to use alcohol as a method to cope with academic difficulties, and their subsequent feelings of discouragement and failure? These theories are further illustrated by studies indicating that the use of chemical substances is positively correlated to a history of physical and/or sexual abuse (Bayatpour et al., 1992; Berenson, San Miguel, & Wilkinson, 1992; Schamess, 1993). Survivors of abuse, especially sexual abuse, often manifest feelings of low self-esteem, unresolved anger, helplessness, and hopelessness, and experience a sense of powerlessness in their relationships. These children may use alcohol and drugs to mask their painful emotions, or the chemical usage may be an unconscious attempt to gain assistance from outside authorities. Research also suggested that childhood abuse is strongly linked to calamitous decisions about sexuality and sexual behavior. Recent studies revealed that children who have survived or are being traumatized by sexual abuse are more likely to become sexually active at younger ages and are at heightened risk for adolescent pregnancy and parenthood (Bayatpour et al., 1992; McCullough & Scherman, 1991; Plotnick, 1993; Rhodes, Fischer, Ebert, & Meyers, 1993; Schamess, 1993).

## ANTECEDENTS FOR AT-RISK ADOLESCENT SEXUAL BEHAVIOR

Adolescent sexual activity, use of contraception, and responses to unplanned parenthood are dependent on many variables. Most adolescents do not intend to become pregnant. The initiation of sexual intercourse is often perceived as an unexpected and spontaneous event, as something that just "happened" (Brooks-Gunn & Furstenberg, 1989, p. 251). Generally, sexual intercourse is precipitated by a serious relationship, although younger adolescents are less likely to be engaged or involved in a steady relationship when they become sexually active. The risk of pregnancy and childbirth is linked to individual beliefs about contraception, decisions about usage, knowledge about effective methods of birth control, and attitudes toward adolescent parenthood (Voydanoff & Donnelly, 1990).

Many younger adolescents are sexually active for approximately 1 year prior to using contraception (Allen-Meares, 1989). The major reasons for this delay include procrastination, fear of parental reprisal, belief that pregnancy is impossible, and fear about the safety of methods of birth control (Zabin, Stark, & Emerson, 1991). Adolescents who clearly understand that pregnancy can result from even one unprotected sexual encounter are somewhat more inclined to use effective contraception than those who do not understand the risks of unprotected sex (Voydanoff & Donnelly, 1990).

Many of the antecedents associated with adolescent pregnancy and childbearing echo conditions linked to disadvantaged socioeconomic status, so it is not surprising that researchers have found that adolescents from impoverished backgrounds tend to become sexually active at younger ages, are less inclined to use effective contraception, and are therefore more likely to become adolescent parents (Voydanoff & Donnelly, 1990). The Alan Guttmacher Institute (1994) reported that although only one third of the U.S. adolescent population lives in substandard socioeconomic conditions, 83% of adolescent parents derive from poor and low-income families. Studies have consistently recapitulated that, regardless of racial or cultural background, all adolescents who experience socioeconomic advantage, family stability, and higher levels of religiosity are more likely to delay onset of sexual intercourse or use contraception at initial intercourse than adolescents from disadvantaged socioeconomic backgrounds. Some studies have indicated that White adolescents are more likely to use contraception than Black adolescents; but when socioeconomic status, family stability, and community milieu are considered, these differences dramatically decrease (Voydanoff & Donnelly, 1990). Likewise, adolescents who chose abortion over childbearing are more likely to live in higher socioeconomic environments, be successful in school, have parents and friends who have positive attitudes toward abortion, reside in communities that provide accessible public-funded abortions, and tend to have fewer friends or relations who are adolescent parents (Furstenberg et al., 1989). Less than 5% of all pregnant adolescents release their infants for formal adoption, and the vast majority of these adoptees are children born to White adolescents from advantaged socioeconomic backgrounds (Cervera, 1993a; Resnick, Blum, Bose, Smith, & Toogood, 1990). Formal adoption has never been an accepted practice among families of African heritage, although frequently young children are informally adopted by relatives. These adoption customs may have evolved due to the generations of racial discrimination experienced by Black people in America (Brooks-Gunn & Furstenberg, 1989) and related fears of Black genocide.

## Developmental Influences

Childhood development is a gradual, steady process that ranges from the dependency of infancy to the self-sufficiency of adulthood (Allen-Meares, 1991). The outcome of this maturation interval is dependent on an interaction between children's unique characteristics, capabilities, and their environment. Throughout this period, children need consistent attachments to adults who protect them and provide the nurture and structure necessary for healthy development. Under satisfactory conditions, as their cognitive processes mature, children are gradually encouraged and allowed to become more autonomous and responsible for their behaviors (Voydanoff & Donnelly, 1990). When children experience adverse childhood conditions, such as neglect, emotional or physical abandonment, poverty, instability, and emotional, mental, or physical abuse, they may experience delays in their developmental growth and fail to form the skills necessary to cope with the challenges and stressors of adolescence and adulthood.

> Youth who live in deprived surroundings, lacking food, clothing, and appropriate housing may not receive what they need from their environment to grow and develop into healthy functioning individuals, and thus could be at risk for a variety of behavioral problems. (Allen-Meares, 1991, p. 332)

## Interpersonal Influences

Sexual activity and responses to pregnancy among adolescents are highly connected to their observations and discernment about normative behavior in their families of origin and peer groups (Brooks-Gunn & Furstenberg, 1989; Voydanoff & Donnelly, 1990). There is a significant probability that adolescents who anticipate a positive response to early parenthood from family or friends will become adolescent parents. This risk is increased when their families or peer group members have a history of adolescent pregnancy and childbearing (Resnick et al., 1990). Conversely, adolescents who expect negative reactions from significant others are more likely to delay sexual debut or avoid pregnancy through the use of reliable contraception (Freeman, 1989). Furthermore, there may be many other underlying multidimensional factors that influence adolescent sexual behavior. For example, pregnancy may be perceived as a method to identify with the value systems of families or peers, as a way to maintain relationships with the family or with sexual partners, or as a means to declare independence from the family. Childbearing may be perceived as an avenue to freedom and autonomy, or as a way to escape from unsatisfactory or intolerable family conditions (Cervera, 1993b; Freeman, 1989; White & White, 1991).

Adolescents who are reared in families that have experienced separation or divorce and families headed by single parents are at elevated risk for early pregnancy. When parents divorce, the lines of communication between parents and children can become distorted and disrupted. Family income may become drastically reduced, and this economic hardship can create stress within the family and adversely affect the parent's ability to nurture and structure their children effectively. Children may be required to cope with reductions in emotional support and simultaneously deal with overwhelming changes, such as a different school, community, or residence. During these difficult times, adolescents may rely more on peers for emotional support and, subsequently, become more susceptible to at-risk behaviors (McCullough & Scherman, 1991; Voydanoff & Donnelly, 1990).

## Environmental Influences

Communities can impact the sexual behavior of young people through educational standards, labor market conditions, attitudes about sexual education, and policies regarding abortion. Children growing up in economically depressed environments have reduced rates of high school completion and lowered expectations toward their future socioeconomic status. Academic performance is significantly connected to adolescence sexual behavior. Students who are academically successful and internalize aspirations for higher education are more likely to either delay initiation of sexual intercourse or use effective measures to prevent pregnancy than students who experience difficulty in school, do not visualize themselves as successful students, and have diminished educational and vocational goals (Bloch, 1991; Brewster et al., 1993; Kiselica et al., 1992; Plotnick, 1993; Whitbeck, Hoyt, Miller, & Kao, 1992).

Career and educational aspirations may be tied to adolescents' perceptions of the opportunity structure of their communities. A high school diploma probably means less to adolescents who lack the resources to pay for college, or those who live in communities with high rates of unemployment. These adolescents may have learned through observation that higher education and career achievement are unattainable goals, and may perceive parenthood as the only route to independence and adulthood. These helpless, hopeless beliefs about future possibilities are exacerbated when parents have not completed high school or are unemployed. (Note that numerous studies have indicated that daughters are significantly influenced by their mother's educational achievement —Voydanoff & Donnelly, 1990.) Furthermore, unlike other adolescent at-risk behaviors, such as suicide, substance abuse, and violence, pregnancy and parenthood are customarily positive and valued occurrences.

In disadvantaged communities, vocational resources and job opportunities may be limited, and when the probability for adequate employment is low, the costs of early childbearing are also low (Patterson, 1990). Young women are particularly impacted by community employment practices. Community values on women in the work force affect opportunities, pay scales, and career advancement for women, and contribute to decisions young women make about their pursuit of and attainability of career goals (Brewster et al., 1993). Adolescent women tend to prevent pregnancy through abstinence or birth control when they expect to achieve higher wages through career development (Plotnick, 1993).

Federal, state, and local policies that regulate family planning education as well as accessibility and financial costs of abortion also affect rates of adolescent pregnancy and childbearing (Plotnick, 1993). Research consistently reveals that availability of abortion does not influence adolescent decisions on the initiation of sexual activity, or their decisions regarding the use of contraception. However, abortion availability increases the probability that pregnant adolescents will terminate unintended pregnancies through abortion and, therefore, decreases the percentage of adolescent childbearing. Data have disclosed that communities with restricted availability to abortion have higher rates of adolescent childbirth, and that birthrates are dramatically reduced when states adopt liberalized laws on abortion (Hofferth, 1991; Plotnick, 1993). In addition, adolescents who live in communities that tend to deny or hide factual sexuality information from children may find it difficult to acknowledge, understand, and cope with their maturing sexuality, and may become at greater risk for unplanned pregnancies (Brewster et al., 1993).

In socioeconomically disadvantaged communities, adolescents, regardless of gender, race, or ethnicity, realistically may not be sacrificing much in income potential or future financial stability by not postponing parenthood. Furthermore, childbearing may allow them to become accepted as adult members of the community (Plotnick, 1993). Brewster et al. (1993) contended "...that community characteristics define behavioral alternatives and their associated social, psychic, and economic costs, thereby shaping the individual's perceptions, attitudes, and values that ultimately guide young people's behaviors" (p. 715).

For example, a community that prohibits the discussion of contraception in the public schools influences the availability of birth control information for adolescents who live in that community and reduces the likelihood adolescents will effectively contracept if they chose to become sexually active. Likewise, when community labor market conditions are poor, young people are less motivated to gain the education necessary for career development. If young people believe they have little chance of securing financial stability through employment, they may place little value on furthering their education and delaying childbirth (Plotnick, 1993). The literature invariably shows that when young people believe they have the opportunity to achieve educational and career goals, they are less apt to become pregnant and jeopardize the achievement of these goals (Brewster et al., 1993).

## CONSEQUENCES

The human and economic consequences of adolescent childbirth are enormous. Whether married or unmarried, adolescent mothers are susceptible to numerous pregnancy-related complications, such as toxemia of pregnancy (eclampsia) and maternal mortality. The high percentage of negative outcomes of adolescent pregnancy is often associated with inadequate prenatal care, poor nutrition and physical immaturity (White & White, 1991). Current data have suggested that reproductive immaturity, pregnancy hormonal deficiencies, distress, and underdeveloped body size significantly contribute to the incidence of premature parturition among adolescents (Stevens-Simon, Kaplan, & McAnarney, 1993). Babies born to adolescent mothers are vulnerable to the adverse effects of premature birth, such as low birth weight, infant mortality, neurological disorders, intellectual impairment, and developmental delays (Allen-Meares, 1989). The risks are even greater among socioeconomically disadvantaged Black adolescents who face the additional distress of discrimination. Studies have indicated the mortality rate of infants born to young Black mothers is almost twice that of infants born to young White mothers (Rhodes et al., 1993).

Infants born to adolescents may be further jeopardized due to the socioeconomic circumstances of their parents. Adolescent parents are less likely to complete high school, less likely to find stable employment, and more likely to live in poverty and become dependent on some form of public assistance. The majority of these young families live in substandard, unsafe, or crowded housing, are nutritionally deprived, and have restricted access to adequate cultural and social advantages. Children of economically disadvantaged families are less healthy and have higher mortality rates than children of economically advantaged families. These children are vulnerable to the adverse conditions associated with poverty, and their quality of life is reduced at the onset of conception (Bloch, 1991; Cervera, 1993a; Combs-Orme, 1993; Foster et al., 1990).

The development of effective pregnancy prevention programs is essential to the welfare and prosperity of our society. Economically, it is far less costly to prevent adolescent pregnancies than it is to direct interventions toward the financial, emotional, and educational assistance of adolescent parents (Hofferth, 1991). The focus of this chapter is on prevention and based on the assumption that universal remedies are necessary for the successful reduction of adolescent pregnancy and childbearing. Therefore, this chapter concentrates on a community-oriented approach to the prevention of adolescent pregnancy and childbearing.

## CASE STUDY: THE STORY OF MARY

Five years ago, Mary was referred to the women's program at a community college by the local Job Opportunities and Basic Skills (JOBS) training program. At that time, she was 32 and the single parent of three children, ages 15, 14, and 8. Her downcast demeanor conveyed a sense of desperation, and her facial expression reflected her feelings of distress and apprehension toward this initial contact. She wore no makeup, yet it was apparent she had made an effort to dress appropriately for this appointment. Despite her intense fear of speaking with a college counselor, Mary courageously began to communicate her feelings of despair, helplessness, and hopelessness about her life situation. Her disclosure revealed that she felt depressed and ashamed of her existence, and that she possessed a drastically limited reservoir of effective life and social skills. Despite her dangerously low sense of self-esteem, Mary demonstrated high intelligence, a yearning for change, the ability to perceive, accept, and internalize encouragement, and a tremendous source of intrinsic strength. It was apparent that buried beneath the layers of abuse, neglect, and trauma was the spirit of a remarkable and talented young woman.

Mary was born when her mother, Sue, was 17, and her father, Jim, 19. She was the oldest of three children. Mary's childhood was chaotic and consisted of extended periods of abandonment and terror. Jim fluctuated between bouts of severe depression and violent rages. Sue was withdrawn and chronically depressed. During her early childhood, Mary's father periodically abused alcohol and began to batter her mother. Her earliest memories of police intervention begin when Mary was about 5 years old, and she remembers a woman came to talk to her. She was told to "keep her mouth shut," and she refused to answer the woman's questions. The authorities did not pursue any further action. Mary's mother attempted to modify Jim's behavior by maintaining a perfect home environment (e.g., clean house, prompt meals, invisible children). Mary's job was to keep the younger children quiet and out of the way; thus she and her mother became responsible for Jim's behavior.

When Mary was 8, Jim lost his job and Sue began work as a swing shift waitress. Mary was given the adult responsibilities of child care, meal preparation, and other household chores. Her father's drinking escalated, and he either forced the children to spend the evening in their bedroom or went to the local bar. At this time he began to abuse Mary physically. The children were often awakened in the middle of the night by violent arguments that culminated into the physical abuse of Sue. Neighbors periodically requested the police to intervene with this pattern of domestic violence, and the police would come, tell Jim to stop beating Sue, and tell Sue to stop provoking Jim's anger.

During her first 2 years of school, Mary was the ideal student. She loved being at school, was bright, eager to learn, and a model female student (quiet, nondisruptive, compliant). During her third and fourth year, Mary's academic performance began to decline dramatically. She was frequently absent. By middle school, Mary was seriously struggling with her school work. She had difficulty concentrating, neglected her homework assignments, and was not involved in any extracurricular activities. She had few friends, rarely smiled, and quietly occupied a desk in the back of the classroom. By the time Mary entered high school, she believed she hated school.

Mary ran away from home when she was 13. The authorities brought her back to her parents. She ran away again at 14, was placed in juvenile detention for 3 days, and returned to her parents. At 15, she made friends with a group of young people who also manifested serious at-risk behaviors and began skipping school, using drugs and alcohol, and having unprotected sexual intercourse with her boyfriend, Allen. Mary was apprehensive about becoming sexually active but complied due to peer pressure and her desire to please Allen. The lack of adequate nurture and positive structure in Mary's childhood and adolescence was directly correlated to the formation of her sense of low self-esteem and her inability to care for herself assertively and effectively.

Mary does not remember learning about birth control at home or at school. She did know what condoms were, but Allen refused to use them. Mary was 16 and Allen 17 when their first child was conceived.

Mary lived in an economically disadvantaged community that had a high rate of unemployment. Jobs were particularly scarce for women. Mary can remember her parents telling her that college was impossible for "people like them." When she learned she was pregnant and would not be able to complete high school, Mary did not believe these events would make a big difference in the quality of her future life. Both sets of parents considered marriage as the only alternative. Both students quit school, and Allen got a job at a gas station.

Mary and Allen's marriage was quite similar to the marriage of Mary's parents. Allen continued to abuse drugs and alcohol, and after a few years, domestic violence became a regular part of their relationship. They divorced when Mary was 29. Since then, she and her children have relied on public assistance programs for survival.

## APPROACHES TO PREVENTION

### Individual

The normal course of adolescent development is filled with upheaval and overwhelming physical, emotional, mental, and social changes. During this passage from childhood to adulthood, adolescents experience a myriad transformations, including an accelerated growth in cognitive abilities. This gradual transition from concrete operational responses to more formal operational thinking generally begins during late childhood and early adolescence. The development of flexible and abstract thinking patterns enables most older adolescents to consider logically the possibilities and subsequent ramifications of certain behaviors, such as unprotected sexual activity or use of alcohol (Allen-Meares, 1991; Brooks-Gunn & Furstenberg, 1989). However, because of the heightened egocentrism and narcissism typical of adolescence, this exploration has a tendency to be self-directed, and adolescents may alternate between concrete and abstract modes of thinking. Consequently, adolescents often become fixated on the here and now, have difficulty determining long-term consequences of intentions, and make decisions solely based on immediate self-gratification (Blinn & Stenberg, 1993).

In addition to the cognitive, physical, emotional, and relational changes of adolescence, young people are faced with the simultaneous emergence of intensified feelings of sexuality and the need to develop a mature value system and formulate guidelines for social and intimate relationships. Social and romantic relationships are critical to the developmental process of adolescence. This process enables children to learn and practice the skills that are necessary for the formulation of more permanent relationships, such as marriage and parenthood.

While young people attempt to cope with the multitude of psychosocial stressors associated with adolescent development, they also strive to establish a unique sense of identity. Identity formation and emotional emancipation from parents are crucial tasks for adolescents (Allen-Meares, 1991; Croft & Asmussen, 1992). During this progressive and difficult process, adolescents struggle toward the achievement of emotional, financial, and functional independence. When differentiation of self from parents is not encouraged or permitted, the adolescent potential to become maturely responsible for self and others may become thwarted (Freeman, 1989).

Adolescents often need practical assistance in building self-esteem and developing life management skills (McCullough & Scherman, 1991). Advocates of the cognitive-behavioral approach to prevention of at-risk behaviors propose that adolescents engage in certain behaviors because they lack relevant information and the skills necessary to utilize that information effectively in life situations. Many proponents of this approach advocate a four-step model to facilitate responsible sexual behavior in adolescents. The first two steps involve comprehending and storing information on sexuality and reproduction as well as on the consequences of sexual experimentation and use of chemical substances. This knowledge is generally transmitted, integrated, and practiced in a small-group format. The second two steps are decision making and decision implementation. Adolescents learn to transform abstract information into everyday reality and how to investigate potential consequences of behaviors. Simulated roles-plays and feedback help group members personalize knowledge about sexuality and drugs, practice newly acquired skills, and learn assertive behaviors (Allen-Meares, 1991).

How might Mary's life have been different if she had received training in assertiveness, self-esteem, and other life management skills? The coping and problem-solving skills Mary received from her parents were minimal and often dysfunctional. Her father coped through alcoholism and abusive behavior, and her mother coped through depression and submissive behavior. She learned helplessness and hopelessness from both parents. The nonintervention of authorities (police, children's services, school professionals) reinforced her sense of powerlessness. Children have an intrinsic need for positive life-sustaining messages, and such interventions might have significantly altered the course of Mary's life.

## Family

The quality of the relationship between parents and adolescents contributes to childhood manifestation of at-risk behaviors. Parental rejection or a lack of warmth and affection is related to emotional problems and developmental delays in moral reasoning, and adolescents who experience deficient communication with parents may become susceptible toward unsafe activities such as drug abuse or unprotected sexual experimentation (Brooks-Gunn & Furstenberg, 1989). Parental neglect, rejection, or abuse is much more predictive of at-risk behaviors in children than is family conflict (McCullough & Scherman, 1991). Studies have suggested that female adolescents from emotionally inadequate environments often become depressed and seek to compensate for this lack of love and support by establishing intimate relationships with nonfamily members. Young males are likely to counterbalance lack of nurture by abusing drugs and alcohol (Whitebeck et al., 1992). Additionally, research has indicated that adolescent sexual activity is highly associated with parental responses to structure. When parents provide structure with abuse, or fail to provide structure (e.g., rules, guidelines, instruction, discipline) and convey a sense of apathy or powerlessness toward parental responsibilities, their offspring have a propensity toward early initiation of sexual activity (Brooks-Gunn & Furstenberg, 1989; Voydanoff & Donnelly, 1990).

Many children are not nurtured by a stable and functional family atmosphere that promotes support and encouragement, and teaches effective problem-solving and coping skills. When parents do not demonstrate or model adequate life skills, children may perceive their own situation as hopeless and fail to develop the necessary skills for survival and growth. In addition, adolescents and children who have not been exposed to self-sustaining skills may become overwhelmed by the natural, yet stressful, circumstances of maturation and development (e.g., academic achievement, formation and maintenance of relationships, peer pressure, sexual growth) and may perceive themselves as powerless. This sense of powerlessness is positively associated with early sexual activity (White & White, 1991).

The family milieu has a most powerful impact on the successful development of our society's children. Young people learn how to function as adults and how to parent their future children in their families of origin. Parents can optimally influence their children's sexual behaviors by (a) providing consistent nurture and structure, (b) limiting opportunities for sexual experimentation, (c) imparting concrete information about sexual intercourse and reproduction, and (d) sharing personal beliefs and values about sexuality (Voydanoff & Donnelly, 1990). Research has revealed that children who are encouraged to discuss sexuality, pregnancy, and contraception openly with their parents generally use protection if they become sexually active (Barth et al., 1992). Communities can promote favorable family interactions by offering parenting programs for adults who were not taught adequate life management skills in their own families of origin. In addition, parental involvement is vital to the efficacy of school or community-based pregnancy prevention programs. Program facilitators can offer workshops on issues related to adolescent sexuality, provide parents with outlines of course curriculum, and encourage family discussions so parents can integrate their value system into educational material (Croft & Asmussen, 1992).

How might Mary's life have been different if the authorities had mandated various interventions for this young family when the unstable conditions first became apparent? Might her life story have changed if her father had received early alcohol abuse and anger management counseling? Perhaps he had a condition that could have been ameliorated by medical treatment. Could her parents have benefited from receiving parenting and life management training? Could therapy have assisted her mother in her ability to care for herself and her children effectively?

## School

The three basic strategies for pregnancy prevention programs can be organized according to the principal objectives of each approach: abstention from or delay or reduction of sexual activity, provision of information and methods to prevent pregnancy and childbearing, and enhancement of self-esteem and instruction on meaningful alternatives to childbearing (Foster et al., 1990; Hofferth, 1991; Plotnick, 1993).

Two major types of educational programs emphasize abstinence or delay of sexual activity. The first includes traditional sex education courses that provide information on sexuality, reproduction, and life management skills (e.g., decision making, problem solving, goal setting). The second teaches assertiveness skills to facilitate a healthy response to sexual proclivity (Hofferth, 1991). The goal of 94% of these programs is to provide education so adolescents can make informed decisions about sexuality. Around 80% of these programs concentrate on education about reproduction, and 40% attempt to reduce adolescent childbearing through promotion of abstinence (Barth et al., 1992).

***Traditional sex education.*** Traditional sexual education courses attempt to delay or reduce sexual activity by providing formal instruction about sexuality and reproduction. These programs may also offer training on life management skills (e.g., decision making, problem solving, goal setting) and social action skills (e.g., sexual and social responsibility, conflict resolution, interpersonal relationship and communication skills) to encourage informed and healthy choices about potential sexual behaviors (Plotnick, 1993).

Close to 90% of all large school districts offer some form of sexual education (Barth et al., 1992), but there are serious limitations connected with most school programs. School-based sexuality education is often noncomprehensive and restricted to topics of biology and reproduction. Educators often avoid the discussion of controversial or sensitive subjects, such as birth control or homosexuality, because of perceptions that this information is unacceptable to parents and other community members (Croft & Asmussen, 1992). (Community members may be more receptive to school-based sex education courses if educators change the title from sex education to sexuality education—Croft & Asmussen, 1992.) Consequently, less than half of school programs provide complete information on sexuality or how to use and where to obtain birth control (Barth et al., 1992). In addition, adults, not adolescents, determine the informational content of the courses.

Surveys have revealed that young people are less interested in learning the biological facts of reproduction than in receiving education on contraception and on social issues surrounding sexuality. Most adolescents want factual and complete information about sexuality, STDs, and AIDS, and they assert that concealing information interferes with their ability to make responsible decisions about future sexual intentions. They regard the tendency of adults to withhold information and decide what children should and should not know about sexuality as an irresponsible action (Croft & Asmussen, 1992). Many professionals agree and maintain that children must be given detailed information on all the methods that will provide protection from disease and prevention of pregnancy (abstinence through birth control) before they can make healthy choices about sexual activity (Allen-Meares, 1989; Barth et al., 1992).

Prevention of at-risk behaviors is a process that begins in early childhood and continues through the latter stages of life. Unfortunately, the majority of traditional sexuality programs are severely time limited (Croft & Asmussen, 1992) and do not accommodate the developmental learning processes of children. Studies have indicated that this hasty, sporadic approach to sexuality education is not effective in reducing the rates of adolescent pregnancy. Moreover, prevention programs often target at-risk groups too late in the developmental cycle (Allen-Meares, 1991).

Many professionals maintain that an effective prevention program for at-risk behaviors of children and adolescents needs to encompass grades K-12 and include comprehensive, developmentally appropriate information that incorporates all aspects of human sexuality and sexual behavior. These programs are not designed to teach young people how to have sex but to help them better understand their emerging sexuality as well as to learn ways to cope with this mysterious, yet natural part of maturation. This learning process begins in early childhood and includes components other than sexual behaviors, such as self-esteem, respect for self and others, sexual responsibility, interpersonal relationship skills, and life management skills (Croft & Asmussen, 1992). The results from school programs that have integrated comprehensive sexuality education in class curriculum for grades K-12 have been highly favorable. Although abstinence is encouraged throughout the educational process, the programs also promote consistent use of effective contraception for young people who chose to become sexually active. Evaluations of these programs reveal this approach dramatically reduces the rate of both premature sexual experimentation and pregnancy (Christopher & Roosa, 1990).

Research has consistently revealed that sex education and family life courses significantly increase student knowledge about reproduction and the biological aspects of sexuality but have little influence on adolescent sexual behavior or rates of pregnancy (Barth et al., 1992; Hofferth, 1991; Voydanoff & Donnelly, 1990). Traditional sex education may have some impact on virgins but does not seem to be effective in reducing sexual activity or promoting the use of protection among adolescents who are already sexually active (Plotnick, 1993).

How might Mary's life have been different if her elementary school had included a prevention program for at-risk students? Could the existence of such a program have encouraged teachers to become more aware of her emotional difficulties? What if teachers had received training to help them detect early signals of potential school withdrawal? What if they had had a convenient source for referral? Might early intervention have empowered Mary to complete her education and realize her full human potential?

***Life management skills training.*** Life skills educators maintain that analytical reasoning processes are necessary to make rational decisions about future sexual behavior. During life management skills training adolescents are presented with factual information about reproduction and taught problem-solving, decision-making, and interpersonal communication skills. Research has suggested that interactions that provide nonjudgmental instruction and encourage self-determination and self-responsibility have a more enduring impact on human growth and development. Consequently, many family life educators recommend that value judgements on sexual or contraceptive behavior be withheld, and adolescents ultimately be allowed to determine their own sexual goals and objectives. This approach provides concrete birth control instruction but also encourages abstinence or delays in sexual activity. Adolescents learn how to anticipate and recognize at-risk situations, problem solve ways to avoid engaging in unprotected intercourse, and simultaneously form and maintain relationships with their peers (Hofferth, 1991). During this didactic process, it is important for educators to use language that facilitates adolescents' comprehension and internalization of proffered messages (Freeman, 1989). Studies have shown that students who participate in life skills programs have better problem-solving, negotiation, and communication skills; greater comprehension of reproduction and contraception; and more favorable attitudes toward regular and effective family planning than do nonparticipating students (Hofferth, 1991).

Adolescents learn best through action, and it is important to get them involved in their own learning processes. Role-plays provide a safe medium in which adolescents can experiment, practice, and become comfortable with healthy decisions regarding their sexuality. Drama and exercises are also excellent interventions for adolescents. For example, all middle school students in one innovative program are given the assignment of caring for an "infant" for 7 days. These infants are actually 10-pound sacks of kitty litter wrapped in pink or blue bags. Students must have these infants with them at all times and tote their children around school in all forms of infant carriers. After school or during the weekend, these student parents must arrange and pay (either through barter or money) for child care. This exercise is an excellent learning tool to help adolescents learn about how it feels to be responsible for a helpless infant. Most begin the week in high excitement, choosing names and dressing their babies in purloined baby clothes. Toward the end of the week, they are scrounging for babysitters, hoping to survive the weekend, and anticipating their impending freedom from parenthood.

The decision tree is another exercise that assists adolescents in the realization that behaviors have consequences. This task helps adolescents carefully scrutinize a proposed action and the outgrowth of that contemplated behavior. The tree's branches sprout with decisions, possible consequences, and potential outcomes of each decision. For example, a heterosexual adolescent considering sexual intercourse looks beyond the decision of initiating sexual activity to the next option, the decision whether to contracept. If the adolescent elects to contracept, he or she next determines whether to obtain information about the effectiveness of various types of birth control and evaluate those potential methods. The decision tree now expands to include choices on whether to learn how to contracept effectively and where to obtain birth control. If the adolescent decides not to contracept, he or she plans for the possibility of a pregnancy or a sexually transmitted disease. If a pregnancy occurs, further decisions include choices of abortion, marriage, child support, adoption, or single parenthood (Kriepe, 1983).

How might Mary's life have been different if she had been encouraged in self-determination and taught she had the right to make healthy decisions about her body, her emotions, and her future goals? Might she have avoided seeking affirmation through the relationship with Allen?

***Adolescent Family Life Act.*** In response to the escalating rates of adolescent pregnancy and childbearing, and the adverse outcomes associated with adolescent parenthood, Congress passed the Adolescent Family Life Act (AFLA) of 1981. This is the first federal program devoted exclusively to addressing concerns about adolescent pregnancy. Proponents of the AFLA assert that premature sexual activity is the main problem, and pregnancy, STDs, AIDS, and childbirth can all be avoided if sexual intercourse is postponed. AFLA programs promote abstinence as a primary prevention for all adolescents and secondary intervention strategies to ameliorate the negative outcomes of childbearing for adolescent parents and their infants. Programs for the AFLA are designed by the Office of Adolescent Pregnancy Programs, and planners assume that the development of internal controls (e.g., self-responsibility, self-determination) will enable adolescents assertively to resist social and personal influences, such as peer pressure, media messages, and natural sexual urges (Christopher & Roosa, 1990; White & White, 1991). These programs promote abstinence through developmentally appropriate skill-building exercises and activities and rely on the use of peer counselors as well as parental involvement and support (Hofferth, 1991).

The AFLA reports of positive results in interpersonal growth and decreases in sexual activity should be cautiously considered because detailed evaluations of AFLA programs are rare, unscientific, nontechnical, brief in content, and methodologically unsound (White & White, 1991). The few scientific studies have indicated that abstinence programs do not influence sexual decisions of adolescents who are not yet sexually active and suggested that this strategy has little effect on the behavior of sexually active adolescents (Plotnick, 1993). Research by Christopher and Roosa (1990) disclosed that programs that rely exclusively on a premarital abstinence approach are not effective in reducing adolescent sexual activity or pregnancy rates. In fact, a study of Success Express, an AFLA program that targets midlevel school children, revealed an increase of sexual activity among participants, particularly male adolescents. In addition, the dropout rate for this program was very high, indicating that students at risk were not motivated to complete the program. Programs that focus on abstinence as the only alternative to pregnancy ignore young people who have already experienced coitus. This exclusion includes the many adolescents who have been forced to endure sexual intercourse through rape or sexual abuse. Moreover, sexually active adolescents may resist courses that strictly promote abstinence because they may hear the message that they have done something bad or wrong, and they may feel defensive, ashamed, and immobilized (Christopher & Roosa, 1990).

***School-based clinics.*** Modern children are faced with learning how to handle multiple adverse environmental conditions, and when they have not been taught effective coping skills, they may respond to environmental deficiencies with behaviors such as suicide attempts, drug or alcohol abuse, and unprotected sexual experimentation. Comprehensive mental health services are vital to this population, and it is imperative that these services are accessible to targeted populations. School-based clinics (SBCs) can fulfill this need (Harold, 1988). SBCs are administered by the school system, located on site at the school or near school grounds, and are a convenient method to serve the mental and physical health needs of students comprehensively. However, although SBCs improve the health care received by students, they show little impact on sexual behavior, use of contraception, and adolescent rates of pregnancy and childbirth.

Research has indicated that community-based clinics located near, but not on, school grounds and not administered by the school system are more effective in reducing adolescent pregnancy rates (Hofferth, 1991; Plotnick, 1993). These statistics may be due to several factors. Although SBCs can serve a vast number of students, clinic schedules revolve around school hours and the school year, and the population served is restricted to registered students. In addition, family planning is generally not a major focus at these clinics. Even when family planning is stressed, students may feel apprehensive about obtaining contraception at the clinic because of problems with confidentiality. Unfortunately, information from student files may be accessible to teachers, or clinic staff may divulge personal information to other school employees. Personnel may not be cognizant of the ethical, moral, and legal aspects or, more importantly, the realistic repercussions of these breaches of confidentiality. Fear of discovery is one of the major reasons adolescents practice unprotected sexual intercourse, and when they believe their privacy may be violated, they avoid using the SBCs' contraceptive services (Zabin et al., 1991).

## Community

Community members, parents, and educators are searching for strategies to reduce the escalating rates of adolescent pregnancies and the growing exposure of our nation's youth to STDs, HIV, and AIDS (Barth et al., 1992). Allen-Meares (1991) proposed that to be effective, prevention programs for at-risk behaviors must (a) target multiple systems (e.g., family, school, community) and use diverse strategies to transmit information, (b) direct intervention efforts toward the entire community, (c) encompass all adolescents and reject assumptions that subgroups are the only students at risk, and (d) focus efforts on encouragement, success, and advantage rather than on deviance or etiology of the problem. Brewster et al. (1993) maintained that the community context is a major influence on the sexual behavior of community youth and suggested that three interwoven factors are crucial to the prevention of pregnancy among adolescents:

1. *community and family attitude*. Adolescents need structured information about appropriate modes of behavior. It is the responsibility of adults to model and define social norms that proscribe, constrain, and delineate acceptable, healthy, and successful behaviors, and clearly communicate the realistic consequences of at-risk behaviors.
2. *provision of hope and possibilities*. Children who reside in communities that empower and encourage goal achievement as well as provide career-related opportunities have positive expectations toward successful accomplishment of educational and vocational goals.
3. *access to contraception*. There needs to be a concerted community and parental effort toward the exposure of youth to knowledge of the reproductive system, complete and factual information about contraception, and accessible family planning clinics.

***Family planning services.*** Contraceptive use among adolescents in recent decades has increased. This trend may be due to an elevated societal concern over the possibility of exposure to AIDS and an impetus toward providing information on protection against this syndrome. However, the majority of sexually active adolescents either randomly use ineffective methods of birth control or completely avoid contraceptive use (Zabin et al., 1991). Studies have indicated that adolescents who experience sexual intercourse at younger ages are more likely to contracept inconsistently, choose ineffective methods of contraception, or engage in unprotected sexual intercourse. Thus adolescents with meager understanding about their sexuality and how to protect themselves sexually are least likely to use contraception.

Simple awareness about sexuality and contraception rarely changes contraception behaviors. Concrete, practical instruction about birth control is positively correlated to contraception use at first intercourse, regular contraception use, and choice of more effective methods of sexual protection. Research has consistently shown that comprehensive knowledge of contraception, more than knowledge of reproduction, significantly lowers practices of unprotected sexual activity among sexually active adolescents. Unfortunately, information about contraception is usually gained from peers, and misinformation about availability, cost, effectiveness, safety, and proper utilization is prevalent (Barth et al., 1992).

Statistics have indicated that adolescents who do use some form of protection often choose methods that are inexpensive and easy to obtain. These methods are generally the least effective forms of birth control. The most effective modes of contraception (e.g., birth control pill, monthly injections, diaphragm, cervical cap) require contact with medical personnel and instruction on usage.

Nonprescription methods of protection (e.g., foam, gel, condoms) are not as effective in preventing pregnancy, but condoms are imperative for protection against AIDS. Adolescents who use condoms rarely receive instruction on correct condom application and removal, and improper use of condoms further increases adolescent risk for pregnancy and AIDS (Voydanoff & Donnelly, 1990).

Family planning services promote sexually responsible behavior by concentrating on increasing regular and effective use of contraception among sexually active youth. It is well documented that family planning programs that distribute contraception and offer information and guidance on abortion and adoption are the most effective method for reducing adolescent birth rates. However, studies have not clearly shown whether these services decrease rates of adolescent pregnancy. Studies have also demonstrated that family planning service effectiveness is enhanced when combined with sexuality education, and sexuality education is more effective when combined with direct access to contraception. In addition, research has not indicated that these services encourage or increase sexual activity among adolescents (Hofferth, 1991). After reviewing the literature that examines the impact of social policies on adolescent pregnancy and childbearing, and the effectiveness of various programs, Plotnick (1993) concluded that "...policies that offer tangible family-planning services and that improve access to and affordability of abortion are more likely to succeed than those that focus on changing personal attitudes and values" (p. 327). He further stated that policies to improve educational and economic opportunities for adolescents are likely to have an indirect, yet important, long-term impact on reducing future adolescent pregnancy and childbearing rates.

How might Mary's life have been different if she had received information that helped her understand her sexuality, her need for intimate relationships, and her emerging sexual desires? What if she (and Allen) had received concrete complete information on human sexuality and use of contraception? Might they have avoided pregnancy?

***Residential programs.*** Prevention works best when it targets communities instead of families and individuals within society (Freeman, 1989) and is directed toward reshaping community climates. Comprehensive residential programs that provide multidimensional services for adolescents can help communities reach goals of reducing at-risk behaviors among children (Hofferth, 1991). These community-based centers can foster propitious changes in community characteristics that can positively impact community youth. Residential programs have several major advantages. The centers are open during periods of idle time, such as weekends, after school, and during vacations, and are available to all adolescents, including those who are withdrawn, suspended, or expelled from school. More importantly, when programs are situated in close proximity to families and the residential environment, family and community members become more involved, and programs are able to tailor strategies that accurately reflect and address conditions within the community (Freeman, 1989; Foster et al., 1990).

***Needs assessment.*** The development and strategic planning stages of a comprehensive community-based prevention center for adolescents require extensive cooperative efforts among educators, parents, and community members (Croft & Asmussen, 1992). Community involvement in the goal development stages of prevention programs is vital to the future success of proposed projects. Involvement not only cultivates the commitment necessary to project sustentation but also critically promotes the identification and resolution of potential areas of disagreement among community members (Croft & Asmussen, 1992; Foster et al., 1990).

During the planning stages, it is important to administer a systematic and accurate assessment of the specific needs of targeted communities. Communities are unique and have precise needs, and generalized programs may fail in certain communities because the needs of the community are not addressed. The needs assessment should focus on (a) identification of existing community resources, (b) limitations in necessary resources, (c) how available resources can be used advantageously, and (d) strategies to make resources available and accessible to community youth (Freeman, 1989). The needs assessment can be accomplished through written questionnaires, semistructured interviews, and use of focus groups (Croft & Asmussen, 1992; Nix, Pasteur, & Servance, 1988). Surveys should include a reliable sample of all community residents (e.g., all ages, economic and educational levels, racial and ethnic groups). After the initial contact that identifies the needs of the community, it may be necessary to gather additional information to further define requirements and specify priorities. In addition, although different groups may agree on certain needs, they may perceive these needs as requiring disparate solutions. For example, adults may devise solutions that do not accommodate the requisites of community youth, and thus jeopardize the successfulness of programs (Freeman, 1989).

***Life options programs.*** Evidence has strongly indicated that student employment opportunities are positively associated with delays in childbearing, and multidimensional programs that combine employment, sexuality and contraceptive instruction, and life options training significantly decrease rates of adolescent pregnancy and childbearing (Christopher & Roosa, 1990; Hofferth, 1991; Plotnick, 1993). The goals of life options programs are to help adolescents understand the consequences of early parenthood, motivate them to defer childbearing, teach life management and interpersonal skills, and provide social and economic alternatives to parenthood. Program strategies include personal counseling, career and vocational training, human development courses, and work opportunities.

High unemployment rates for adolescents within their immediate communities can decrease opportunities for work experiences and prevent the acquisition of career-related knowledge. In economically depressed communities, it is difficult for adolescents to internalize an image of themselves as responsible, working adults. This frustration of the ability to visualize and develop career goals can negatively impact the self-worth of male and female adolescents. Furthermore, adults in economically disadvantaged communities are also impacted by high rates of unemployment and may be less capable of modeling positive career-related behaviors and providing adequate guidance about career preparation (Freeman, 1989).

Hofferth's (1991) review of the effectiveness of programs for high-risk adolescents revealed some promising results for community-based prevention programs. Research data from Youth Incentive Entitlement Pilot Projects (Olsen & Farkas, 1987) indicated that when adolescents are guaranteed a job (part time during school year and full time during summer vacation), they are more likely to delay childbearing. The program evaluations demonstrated that after 2 years, program participants, when compared to the control group, had substantially higher levels of knowledge about sexual reproduction and contraception, had a greater tendency to delay initiation of sexual activity, and were more likely to use contraception when sexually active. There was a 30% decrease in pregnancy rates for older adolescents compared to a 58% increase in nonparticipants.

A more comprehensive approach was developed in 1985 by Public/Private Ventures. This experimental project, Summer Training and Education Program (STEP), was designed to reduce rates of early school withdrawal, school suspension, course failure, and pregnancy rates among adolescents from disadvantaged socioeconomic backgrounds. The randomly selected STEP participants were provided with remedial education (90 hours of reading and math tutoring), sexuality education and life skills training (18 hours of learning how to make responsible decisions about social and sexual behaviors), work experience (80 hours of part-time work provided by the local youth jobs program), and a comprehensive support system throughout the entire year. The control group received full-time summer employment and no other special treatment. Program evaluations revealed that the experimental group showed increases in effective use of contraception when sexually active and were more likely than the control group to delay initiation of sexual intercourse.

How might Mary's life have been different if, since childhood, she had carried an image of herself as a productive, worthy, self-empowered, and satisfied working adult? What if she had been encouraged to set goals and to visualize herself as capable of achieving these goals, and could depend on obtaining or earning the resources necessary for attaining these goals? What about other young women like Mary?

## INTERVENTION

There are critical implications for intervention that must be integrated into program development. Successful prevention efforts require enabling teens, both male and female, to avoid additional pregnancies and providing compelling reasons for them to do so. The greater the access to sexually specific information and services, the greater the likelihood that they will take responsible steps to avoid a second unintended pregnancy. The stronger the reasons to avoid pregnancy and the greater the perceived impact of an unintended pregnancy on their present activities and future plans, the greater the likelihood that adolescents will take steps either to refrain from sexual activity or to be responsible to their partners. Paternity acknowledgement, formal paternity establishment (through marriage or other legal means), child support establishment, and child care will either motivate adolescents to become involved in the new life they created or seek acceptable alternative solutions to pregnancy or child rearing. The long-range implications transcend all aspects of child and adolescent development.

Intervention programs for pregnant or parenting adolescents predominately focus on adolescent females and are directed toward the facilitation of healthy pregnancies for mother and infant, completion of education, resolution of immediate and long-term social and emotional difficulties, deferral of subsequent pregnancies, acquirement of self-sufficiency skills, and economic independence (Hofferth, 1991). Pregnant and parenting adolescents frequently need preliminary subsistence assistance, and this support is typically acquired from parents, public assistance, and nutritional programs such as food stamps or the Special Supplemental Food Program for Women, Infants, and Children (WIC), which provides nourishment for eligible pregnant and lactating women and children up to 5 years of age. Evaluations of WIC show this program is successful in improving the outcome of pregnancy for mother and infant and can have the strongest positive impact on at-risk adolescent mothers (Allen-Meares, 1989). The two major public sources for assistance are Aid to Families With Dependent Children and Medicaid. Medicaid has eliminated a previous connection with AFDC and is now expanded to provide health care assistance to multifarious groups of women (Combs-Orme, 1993).

An important function of intervention programs is to provide information and referrals to accessible resources. Thus professionals who work with adolescent parents should be familiar with, and understand the eligibility requirements and application procedures of, all federal, state, and local services available to adolescent parents. In addition to financial, medical, and nutritional assistance, referrals can include mental health and other support services, adoption/abortion clinics, child care, programs that provide clothing and other basic needs, housing, and educational options (e.g., alternative schools, High School Equivalency Program, community colleges, vocational training) (Combs-Orme, 1993).

Adolescent mothers list transportation, child care, support groups, and counseling services as top priorities for assistance programs. Support groups are an important intervention for pregnant and parenting adolescents. Approval and support from peer groups is an imperative need for most adolescents. Unfortunately, pregnant female adolescents are often rejected by their friends and classmates (Blinn & Stenberg, 1993). These young mothers feel comfortable with other young women who are experiencing similar situations and value the acceptance, nurture, encouragement, and constructive feedback these peer groups provide. In addition, young mothers report that lack of transportation is a serious obstacle to completing education and obtaining medical assistance. Even when financial assistance is provided for child care, the use of public transportation to get their child to day care, go to school, and pick up the child after school is often perceived as an overwhelming barrier (McCullough & Scherman, 1991).

## Community

Although early and regular prenatal and postnatal care significantly reduces the health risk to infants and their mothers, utilization of available services by low-income pregnant and parenting women is extremely low. Research has indicated several factors that may contribute to the underutilization of prenatal and postnatal services for pregnant and parenting mothers. These include (a) reduction of services due to governmental cutbacks, (b) difficulties with child care and transportation, (c) programmatic barriers (e.g., inefficiencies, confusion about eligibility, application procedures, long lines), (d) inappropriate behaviors of staff (e.g., judgmental attitude, intrusiveness, discrimination), and (e) treatment and assessment strategies that are biased toward the dominant segment of the population. Women who experience discrimination, depression, or other psychological difficulties, or feel disempowered are the population who will benefit most from these services, yet they typically do not initiate and sustain program assistance (Rhodes et al., 1993).

The propensity to defer prenatal care is further increased among disadvantaged adolescents, and the youngest adolescent group, whose babies are at the greatest risk, are the least likely to seek medical assistance (Combs-Orme, 1993). It is important that professionals consider the unique adolescent characteristics that can underlie adolescent disuse of medical care. Adolescents may fail to seek prenatal care due to immature cognitive processes and lack of knowledge. Their thinking processes are often concrete and existential, and the concept of a child developing within the body of a young female may be too abstract for her to understand (Christopher & Roosa, 1990). Younger adolescents may not be knowledgeable about the symptoms of pregnancy and may not initially realize they are pregnant. Sometimes adolescents delay the commencement of prenatal care during the critical first trimester because they are undecided on how to resolve the pregnancy or want to deny the fact they are pregnant. Denial can emanate from magical thinking processes (ignore it and it will go away) or as a way to cope with the perceived consequences of discovery. For example, adolescents may avoid acknowledging the pregnancy because they fear parental reactions or are anxious about medical tests and pelvic examinations (Combs-Orme, 1993).

Public nutritional resources are available to pregnant and lactating adolescents, yet many young women do not take advantage of these services (Combs-Orme, 1993). Typically, adolescents gain less weight during pregnancy, and their nutritional intake is often poor. Consequently, they are at heightened risk for being malnourished during gestation. Inadequate maternal weight gain in adolescents is correlated to the maternal and neonatal risks linked to adolescent childbearing (Stevens-Simon et al., 1993).

Many factors are associated with poor nutrition and insufficient weight gain among pregnant adolescent females. Adolescents frequently experience feelings of negativity about their body image. These feelings are especially intense during periods of rapid growth and extensive physical changes. Studies have indicated that when adolescent women are pregnant, their perceptions of self-image, self-esteem, and self-identity are further diminished. This may lead to an increased need to conform to the current societal message that only extremely thin women are attractive and thus create a conflict between complying with the societal mores of thinness and the need to gain weight during pregnancy (Blinn & Stenberg, 1993). Malnourishment is exacerbated by the combination of reduced nutritional consumption and an immature reproductive system that requires additional sustenance. Reduced nutritional intake could be due to typical teenage eating habits (e.g., skipping meals, eating junk food) or may derive from conditions in which adolescents are unable to afford sufficient amounts of healthy food or from supplemental food programs that do not meet the special nutritional needs of pregnant adolescent females. Finally, adolescent mothers are vulnerable to depression, and this affective disorder can precipitate a failure to thrive in children. Adolescents who fail to gain weight during gestation should be evaluated for depression (Combs-Orme, 1993).

Pregnancy prevention and intervention programs for adolescents need to include information on nutritional requirements during pregnancy and stress how weight gain is necessary for the health of the mother and unborn child (Blinn & Stenberg, 1993).

## Individual

It is imperative that professionals consistently consider the individual developmental stages of the pregnant adolescent. "It is easy to forget that pregnant adolescents are still children, subject to the same cognitive and emotional limitations as any child" (Combs-Orme, 1993, p. 353). Ideally, adolescence is a time for children to define and establish their self-identity and learn and practice the skills of adulthood. Conversely, pregnancy is a time for adults to prepare for childbirth and learn to meet the impending needs of their unborn child. The conflict between these natural processes can manifest in intensified feelings of distress and instability in adolescents as they struggle to fulfill both developmental tasks (Christopher & Roosa, 1990). Professionals can facilitate healthy resolution of this dichotomy by focusing interventional efforts toward the needs of both the parents and the infant. When adolescents are assisted in fulfilling developmental goals, and resolving their feelings about the pregnancy, they become more capable of nurturing and caring for their unborn or newborn infant (Combs-Orme, 1993).

The combination of the immature cognitive processes of adolescence and the trauma of pregnancy may distort young people's ability to make rational decisions on how to resolve the pregnancy. Thus many adolescents may need crisis intervention counseling when they first admit they are pregnant. They may feel overwhelmed and immobilized, and need strategies that can assist them in becoming calmer, less emotional, and more capable of solving problems and making crucial, life-consequential decisions (e.g., adoption, abortion, marriage, employment, education). It is important that health care workers assist adolescents in planning for their future and encourage them not to lose sight of their long-term dreams. Often adolescents experience instant gratification when they earn a minimum wage, and they may tend to discard long-term plans for education and career. Professionals can help adolescents problem solve, make long-range plans, and realize these former goals are not only accessible and attainable but also vital to the adolescent's future quality of life (Combs-Orme, 1993; Kiselica et al., 1992).

There is a growing trend for policies and programs to encourage young unwed fathers to establish paternity legally for their children. Fathers who establish paternity legally have a basis for asserting their rights with regard to visitation, adoption, and custody decisions. Concurrently, legal paternity permits children to have knowledge of the identity of their fathers, allows them access to Social Security or military benefits, provides them with the opportunity to seek important medical information about their fathers, and, if followed by child support, enhances their economic well-being.

Paternity should be legally established as soon after the birth of the child as possible at a stage when the father is most motivated to be involved. It has also been suggested that minors be approached differently than unwed fathers who are legal adults. Inherently, in the case of teen parenthood, the legal rights of these children are serious developmental and economic concerns. The minor father must not only show a significant parental interest but also parent fitness. For unwed fathers under 18, financial obligations might be postponed until adulthood with provisions for token support or in-kind services such as child care.

### School

Many studies have indicated that postnatal services are effective in reducing subsequent pregnancies for adolescent mothers. A longitudinal study conducted by Seitz and Apfel (1993) examined the effects of female adolescents' postnatal attendance at a public alternative school for pregnant adolescents.

This school adheres to the regular school calendar, schedule, and curriculum, and provides students with medical services, prenatal and parenting classes, life management skills training, and mental health counseling. The goal of school personnel is to promote and encourage development of self-sufficiency skills. Usually pregnant adolescents remain at the alternative school until their infant is born and return to regular school the first quarter following the birth. However, students who deliver during the third quarter are allowed to complete the fourth quarter at the alternative school. Consequently, students who experience parturition January through April are permitted to remain at the school longer than students who deliver May through August.

Information gathered by Seitz and Apfel (1993) on 102 alternative school female students revealed that students who were allowed to remain at the alternative school for 7.1 weeks or longer were almost three times less likely to have a second child within a 2-year period than were students who returned to regular school in less than 7.1 weeks. After 5 years, over half of the single child group had not delivered a second progeny. Adolescents who did not give birth to a second child within 2 years had significantly better educational outcomes (e.g., passing grades, high school diploma) than did students who delivered a second child. In addition, adolescent mothers who deliver a second child within 2 years are inclined to have larger families, abandon hope for educational and vocational achievement, and rely on public assistance to support their families.

Seitz and Apfel (1993) proposed that there is a critical interval during the second postnatal month in which adolescents make pivotal decisions about future sexual responsibilities and the consequences of their sexual behaviors. The availability of an effective support system during this time period promotes the probability that young mothers will make decisions that lead to more positive life outcomes. It appears "...that intervention with economically disadvantaged women is especially effective when it begins during the pregnancy with the first-born child and continues postnatally" (p. 580).

## DIVERSITY

Our society is failing to educate approximately one third of our population (Bloch, 1991). The risk for noncompletion of education is dramatically increased for adolescent parents, young people who live in urban areas, and members of certain ethnic and racial groups (Barber & McClellan, 1987). For example, high school noncompletion rates are dangerously high for students of

Native American and Puerto Rican descent (Barber & McClellan, 1987). Research that investigated conditions leading to high rates of high school noncompletion has predominately focused on the individual, family, and socioeconomic status as possible contributing factors. Despite the vast amount of research directed toward identifying students who are at high risk for early school withdrawal, not one component or combination of circumstances has emerged that clearly predicts adolescent at-risk behavior (Bloch, 1991).

Some studies have seemed to indicate that lower socioeconomic status, limited educational background of parents, and being born to a certain ethnic or racial group are highly predictive of at-risk behaviors such as drug abuse, adolescent pregnancy, or high school noncompletion. Meyer (1991) found a cultural bias in the majority of medical and social science research:

> The terms *inner city*, *urban*, and *lower socioeconomic status* were frequently conflated with Blacks and other minorities. This conflation makes Blacks and/or other minorities of higher socioeconomic status (in addition to Whites of lower socioeconomic status) virtually invisible. It also does not differentiate among factors associated with economic status, minority status, and/or cultural factors. Conflating race and ethnic groups with socioeconomic status may also serve to perpetuate discrimination by normalizing the privileged status of the majority group in our society. (p. 221)

For example, many people believe that adolescent pregnancy and childbirth is primarily an African American problem. The facts are that although the rate of Black adolescent childbirth is higher than the rate for White adolescents, the incidence of White adolescent childbirth is much greater than that of Black adolescents. Furthermore, racial differences in rates of sexual activity, pregnancy, and childbirth have declined in recent years. During the past 40 years, the rate of pregnancy has increased by more than 300% for White adolescents and by 12% for Black adolescents (Meyer, 1991).

Few studies have researched the impact of teachers and the educational system on high school noncompletion rates and the instructional institution's role in determining educational outcome (Dearden et al., 1992). The focus on factors that are beyond the scope of influence of public agencies may significantly contribute to the paucity of studies that investigate the school system as a possible contributing variable of high school noncompletion rates. If educators believe that certain at-risk behaviors and subsequent school withdrawal are racially or ethnically related, that there is little they can do to change the circumstances, they may make few attempts to reduce the dropout rates among these populations (Bloch, 1991).

> If as profiles of dropouts seem to indicate, schools are not successful with identifiable groups of students, it is not enough to know it is so, one must ask *why* it is so. Have schools acted in ways that may be interpreted as alienating to students with cultural backgrounds different from the dominant culture? In general, what

> interactions between schools and students are counterproductive to learning, indeed to staying? How can schools change these interactions? (p. 44)

Ultimately, the standard public education system is not sufficiently responsive to the needs of culturally diverse groups, and many students are underserved because of the tenacious disposition to advance and preserve educational procedures that predominately comply with requirements of the dominant culture. Research needs to address the interaction between school systems and populations that are at higher risk for high school noncompletion because they do not conform to the profile of an "average" student and to investigate educational procedures that are successful in reducing their withdrawal from school (Bloch, 1991).

Studies also need to be directed toward examining the behaviors students exhibit prior to withdrawal so educators can plan more effective strategies for prevention. Students may delay physical withdrawal from school until they are in junior high or high school, but they may begin to leave emotionally and mentally in much earlier grades. In addition, students who behave in ways that increase the possibility of suspension or expulsion from school may be surreptitiously withdrawing from school. When a student who has negative experiences in school is suspended, the suspension may be reinforcing for that student. Is it possible that our educational system discourages the participation of students who do not fit the norm of the average student, and covertly or overtly attempts to remove these students from the system? The consequences to breaking rules in school seem to be irrevocably connected to subsequent denial of education. Does it make sense to suspend or expel a student for truancy?

The tendency of research to focus on factors unrelated to school responsibility for dropout behaviors may emanate from ideology that promotes the belief that it is easier to fix certain students so they can function better in the traditional educational setting than it is to change the educational system to accommodate the diverse needs of students. When children feel culturally or racially isolated, and when their style of learning does not conform to the traditional modes of education, they may feel discouraged, disempowered, and alienated, and thus cease to pursue their education. All students have the right to feel involved and accepted in the classroom, and educators must examine their roles in the estrangement of certain students (Wehlage & Rutter, 1986). The focus of prevention must shift from attempting to mold students to adapt to standard educational criteria to determining how the school system can be restructured to recognize and respond to the diverse requirements of all students.

## CASE STUDY AFTERMATH

Mary enrolled in the community college and used various free services (e.g., personal counseling, group counseling, and human resource classes) to learn more effective life management skills and improve her emotional well-being. She received her associate degree in 1993 and her bachelor of arts in psychology in 1995. She has been accepted by a graduate program to complete the educational requirements necessary for the fulfillment of her dream, counseling children from disadvantaged environments.

## SUMMARY

The continued increase of pregnancy rates among adolescents in the United States implies that the strategies established by current programs to prevent adolescent pregnancy are not working. Many variables contribute to the effectiveness of intervention programs. For example, problem definition, setting, project design, curriculum, and execution of services are important determinants of program performance. However, even excellently designed pregnancy prevention programs may be unsuccessful when the target group is already engaging in risk-taking sexual activity. Studies have suggested that pregnancy prevention programs are more successful when they incorporate multiple systems (e.g., community, family, school) and when participants have not experienced sexual intercourse. Consequently, professionals recommend starting comprehensive sexuality education in elementary school because programs that target preadolescents have a greater likelihood of reaching young people before they become sexually active. However, many adults believe sexuality education promotes sexual activity and resist comprehensive sexuality programs, especially those that provide information about birth control or that encompass preadolescents. Although studies reveal sexuality education does not encourage or increase sexual experimentation, program developers often comply with societal preferences, modify middle school and high school curriculum, and avoid offering sexuality education to elementary school students. Regardless of this attempt to deny sexuality education to our nation's children, more preadolescents are initiating sexual activity each year. Unfortunately, because of their lack of knowledge and immature thinking processes, American children are becoming increasingly vulnerable to the negative consequences of unprotected sexual activity (e.g., pregnancy, AIDS, STDs). Moreover, when children rear children, the repercussions for the young parents, their offspring, and our society are enormous. Thus the development of responsible and effective pregnancy prevention programs is essential for the protection and preservation of our nation's future generations.

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# 10

# Adolescents and AIDS: Education, Compassion, and Reason

*Lizbeth A. Gray and Reese M. House*

> Joshua is a 17-year-old American teenager. He has been diagnosed with AIDS. He contracted the virus through sexual experimentation. He has dropped out of high school. His neighbors have erected a fence to protect themselves from "contracting this terrible disease." His friends have rejected him. His brothers and sisters are afraid to be with him. His mother and father cry and feel helpless in the battle to keep him alive. He now weighs 86 pounds. He is often too sick to go out of the house. He will probably die soon. Joshua is very frightened.

It is relatively easy to talk about high-risk groups for HIV/AIDS, projected numbers, causal agents, transmission processes, and prevention strategies in an intellectual and objective manner. It is harder to speak of Joshua's death and dying process. It is difficult to embrace the pain that his family experiences as they lose someone they love. It is frustrating to deal with institutions and communities that contribute to a family's pain through roadblocks erected from ignorance. This chapter focuses on HIV/AIDS information that we need to know as counselors working with adolescents. It may seem distant and removed. But all of us need to learn about HIV/AIDS, integrate the information, and open our hearts to the anguish that HIV/AIDS is causing our society. We must learn to understand this disease with both our minds and our emotions.

Evidence has been mounting that the human immunodeficiency virus (HIV), which causes AIDS (acquired immunodeficiency syndrome) is spreading rapidly among adolescents in the United States. As of December 1994, 1,965 teenagers between the ages of 13 and 19 had been diagnosed with AIDS (Centers for Disease Control and Prevention, [CDC], 1994). This small number is misleading because HIV has an average latency of 10 years. CDC reported in 1994 that 16,575 Americans between the ages of 20 to 24 years had been diagnosed with AIDS. Due to the long latency period, virtually all of these young adults are believed to have contracted the virus while in their teens. Ramifications of this crisis are far reaching, and there is no doubt that the health and welfare of today's adolescents are in jeopardy. The HIV/AIDS pandemic is having a tremendous social and psychological impact on individuals, families, schools, and communities.

There is no cure for HIV disease and no vaccine; thus adolescents will continue to be vulnerable to HIV infection and AIDS for the foreseeable future. Adolescents are at risk for HIV because they are sexually active, often do not use condoms, may have multiple sexual partners, and do not use precautions if they believe that their partner is safe. A small percentage of teens are also intravenous drug users. As adolescents continue to engage in unprotected sex and to use drugs intravenously, the risk escalates.

Teenagers have a hard time believing that contracting HIV is a possibility for them. Only a small number of the thousands of teenagers infected with HIV are aware of their sero-positive status; and those who know they are positive often keep it secret to avoid rejection by peers or family. Because their peers do not manifest symptoms of the syndrome, it is easy to understand why teenagers in general do not see themselves at risk for HIV/AIDS. The image of AIDS as a disease of gay men and intravenous drug users has also allowed youth to feel invulnerable to HIV. Even teenage boys who experiment with unprotected sex with other males may not see themselves at risk if they do not self-identify as gay. Others believe that they cannot get HIV/AIDS from someone with whom they are in love or with whom they engage in serial monogamy. It is difficult to counter these myths when messages from some parents, churches, and government agencies continue to put forth the idea that monogamy, marriage, and love are equated with health while promiscuity and drug addiction are the only sources of HIV/AIDS.

Adolescents take risks on a daily basis. No magic bullets have been found to prevent teenagers from becoming pregnant, from driving dangerously or when drunk, or from abusing drugs. Indeed, the only possible effective weapons in the fight against the spread of HIV are education, compassion, and reason. Prevention and intervention programs that are sensitive to cultural and ethnic diversity need to be directed toward adolescents, families, schools, and communities. Contemporary and accessible services that address developmental needs must be designed for all adolescents. The role of the family must be targeted in all HIV/AIDS education efforts. States must include HIV/AIDS prevention programs as an integral part of comprehensive health education for elementary and high school students. All concerned groups need to develop special educational outreach programs for hard-to-reach groups of teenagers engaging in behaviors that put them at high risk of becoming HIV infected.

## PROBLEM IDENTIFICATION

### Factual Information About HIV/AIDS

The cause of AIDS is believed to be a retrovirus that targets and destroys certain white blood cells essential to the functioning of the body's immune system (Levy et al., 1984). Once the immune system is severely depressed, opportunistic infections develop that typically cause death. Once an individual contracts the AIDS virus, he or she is infected for life. There is no cure for HIV, and none is predicted in the foreseeable future.

HIV is not as contagious as other well-known viruses such as the common cold, and it is not transmissible through casual social contact such as coughing, sneezing, shaking hands, sharing eating utensils, or using the same telephone. The virus is actually quite fragile and is quickly killed on environmental surfaces when treated with disinfectants. Medical authorities repeatedly state that transmission only occurs through three modes: sexual contact, exposure to infected blood or blood products (e.g., sharing needles, blood transfusions), and passage of the virus from a woman to her fetus or newborn infant. In addition to blood and semen, vaginal and cervical secretions are known to contain the virus and may account for female-to-male transmission. It is thought that the vast majority of HIV-infected persons are carriers who are unaware that they have been exposed to the virus but are nevertheless capable of infecting others. Saliva, tears, urine, cerebrospinal fluid, and feces may also contain traces of the virus in infected persons, but not in amounts sufficient to transmit the virus to another person.

Since HIV/AIDS was first reported in the United States, the persons diagnosed have been predominantly homosexual or bisexual males. In other areas of the world, however, heterosexual transmission of HIV accounts for the clear majority of cases. In the United States the percentage of heterosexual AIDS cases increases each year. Of the total AIDS cases reported as of December 1994, 7% contracted the virus through unprotected heterosexual activity (CDC, 1994). HIV/AIDS is a problem among all races, but a highly disproportionate number of Blacks and Hispanics are infected with the virus in the United States. Approximately 25% of AIDS cases in the United States are among Blacks, who comprise 12% of the American population, and 14% are among Hispanics, who comprise 6% (CDC, 1994; Jemmott, Jemmott, & Fong, 1992).

The average time between HIV infection and the onset of symptoms is approximately 10 years (CDC, 1994; Smith, McGraw, Crawford, Costa, & McKinlay, 1993). Symptoms include tiredness, fever, loss of appetite and weight, diarrhea, night sweats, and swollen lymph glands, all of which are similar to the symptoms of the common cold and flu. Unlike the common cold, symptoms of the person with AIDS are ongoing and persistent. Also, the virus frequently affects the brain and central nervous system causing confusion or dementia.

People living with AIDS (PLWAs) frequently contract life-threatening infections such as Pneumocystis carinii pneumonia or a type of cancer known as Kaposi's sarcoma. With the advent of improved medical practices and experimental drug treatment, people are living longer with AIDS.

## Adolescents Are at Risk

In 1994, AIDS had become the number 6 killer of youth, exceeding the number of deaths resulting from automobile accidents (CDC, 1994). HIV is primarily spread among teenagers through unprotected sexual contact with an infected person or by sharing a needle with an infected person in the course of intravenous drug use. These two means of HIV transmission account for 89% of all AIDS cases among people 13- to 24-years of age. Also, there is evidence that most adolescents do not seek health care on a regular basis, thereby increasing the chance that HIV/AIDS may go undetected (Ennis, 1987).

By age 18, approximately three quarters of all boys and almost two thirds of all girls have been sexually active (Yondorf, 1992). Further, teenagers are initiating sexual intercourse at younger ages. Two recent national surveys reported that about one third of 15-year-olds reported having had sexual intercourse (Miller, Turner, & Moses, 1990; Sexuality Information and Education Council of the United States, 1994).

A 1993 study of 239 undergraduates showed that 90% had sexual intercourse within the last 12 months. Nearly two thirds of the students reported having had vaginal intercourse during this same time period without using a condom, even though they were knowledgeable about the risks of contracting AIDS (Gray, 1994).

Sexual activity with other males appears to have been the primary means of acquiring HIV for 34% of males with AIDS aged 13 to 19 (CDC, 1994). Similarly, "sexual activity between males also accounted for 66% of AIDS cases in 20- to 24-year-old males, an important finding considering most of these young men were infected with HIV during adolescence" (Rotheram-Borus et al., 1994, p. 47). Some adolescents experiment sexually with homosexual/bisexual men and/or intravenous drug users; thus a bridge or chaining effect is established for transmission of the virus to the larger teenage population. As a result, teenagers typically contract HIV/AIDS from such chained contact rather than direct homosexual contact or intravenous drug use.

Also increasing the adolescent's risk for HIV/AIDS is the high percentage of teens who have tried drugs or who use drugs and alcohol on a regular basis. Chemical substances are known to impair the immune system, contributing to susceptibility for contracting AIDS. Use of alcohol or drugs such as amphetamines (speed), amyl nitrite (poppers), cocaine, and marijuana impair judgment and increase the chances of risky sexual behaviors or the sharing of needles.

With these disconcerting facts, there is some encouraging news. Among those aged 17 to 19 living in metropolitan areas, condom use has increased over the last decade from 21% to 58% (Yondorf, 1992). Further, accurate AIDS knowledge gained by adolescent boys leads to more tolerant attitudes (Steitz & Munn, 1993). A solid majority of college students surveyed (85%) said PLWAs should be allowed to attend public schools (up from 63% in 1988); and only 33% said they would be worried for their personal health if a co-worker had AIDS (down from 50% in 1988) (Gray, 1994). In this same college student study, undergraduates also showed a greater willingness to talk with potential partners about protection against HIV, and four times as many students in 1993 expressed willingness to test for HIV than 5 years earlier.

Overall, due to the high frequency of sexual activity, failure to use condoms and spermicides, inadequate health care, drug involvement, and the chain effect resulting from experimentation with homosexual contact, teenagers are particularly vulnerable to contracting HIV/AIDS. The fact that teenagers are not changing risky behavior supports the premise that it is very difficult to convince adolescents to believe in the dangers of HIV/AIDS. This is due to several factors, including their susceptibility to negative peer pressure; propensity to take risks, including sexual and drug experimentation; sense of invulnerability and immortality; and difficulty grasping the long-term adverse consequences of current behavior (Bowler, Sheon, D'Angelo, & Vermund, 1992).

## Response of Teens

Panic, hysteria, and denial are common responses to HIV/AIDS among adolescents. When examining these psychological reactions, it is critical to understand the way in which parental and community attitudes affect children's thinking. Often public attitudes about HIV/AIDS, based in part on misinformation and fear of sexuality and AIDS, manifest themselves through teenagers.

Adolescents' anxiety about contracting a deadly disease through sexual activity is heightened by embarrassment concerning sexual intimacy, which is common to the normal developmental processes of adolescents. Many teens seem to have factual information about reproduction, birth control, and safer sex practices but lack the skills and maturity necessary to talk about these issues effectively with a partner.

Similarly, some adolescents exhibit a lack of concern or denial with respect to the AIDS epidemic, believing that they are invulnerable. This belief in personal invulnerability, particularly in relationship to health issues, is also an intrinsic developmental feature of adolescents and points to maturity as one key factor in developing a healthy sexuality. Most teenagers judge their risk level by imagining a stereotype of who will be involved in a negative event such as contracting HIV/AIDS (Bauman & Siegel, 1987; Weinstein, 1984). People associate AIDS with gay men or intravenous drug users and distance themselves from the possibility of contracting AIDS. This process has been labeled by Weinstein (1984) as *unrealistic optimism*.

## CASE STUDY: THE STORY OF JOSHUA

Joshua is one of thousands of American teens who is HIV positive. Although there are similarities between his experiences and those of others, it is important to realize that his situation is unique to him. Each adolescent is an intricate web of emotions, cognitions, personal experiences, physical needs, relationships, and genetic composition, and consequently, counselors must expect that there will be no two cases exactly alike. We can learn from Joshua, but his situation does not offer a prescription for responses to other youth who are struggling with HIV/AIDS.

***Identifying characteristics.*** Joshua is a frail, yet bright-eyed, 17-year-old White male who was diagnosed with AIDS 6 months ago. He currently lives with his family. The initial counselor-client contact took place in the home upon recommendation of his physician.

***Presenting problem.*** Joshua's presenting problem was "Please help me; I don't want to die."

***Family history.*** Joshua is the oldest of five children. He has three brothers ages 15, 14, and 11 and one sister age 9. The family had been active in the Catholic Church, and the two younger children attend Catholic schools. Joshua's father is 45 years old and works in middle management in a high-tech corporation. His mother is 43 years old and works part time as a librarian at the city library. Joshua describes a history of "happy family vacations" and frequent outings until his preteen years. In the last year, the family has experienced financial stress and subsequent withdrawal of his father due to a "need to make more money." Joshua's mother expressed that at the same time she has felt "helpless about the entire situation" she sees herself providing continuity to the family. In the absence of his father, Joshua describes taking over the role of second parent to the two younger children.

***Educational history.*** Joshua's grades in his first 3 years of high school ranged between C+ and B-. He is particularly gifted at computer science. Joshua has always been a vocal student in the classroom, and he describes his first 3 years of high school as "pretty good." He started his senior year of high school, but due to negative community reaction after his diagnosis became public about 1 month ago, he chose not to finish the first semester.

***Social history.*** Joshua describes himself as a well-liked student in high school until his diagnosis. He relates that his friends "have not contacted me since they learned I have AIDS." He was active in sports, particularly basketball, and extracurricular activities such as the computer club. He dated frequently and related being sexually active with at least two of his past three girl friends. Joshua had many nonsexual female friendships during his first 3 years of high school.

More recently he relates social isolation due to his diagnosis of AIDS. Joshua has not gone outside the home for close to a month. He said he was bitter the way his "family doctor's receptionist opened her big mouth" and told others of his AIDS diagnosis.

***Employment history.*** Joshua has worked part time at the library since he was 15 years old, particularly on weekends and during summer vacations. He has been unable to work recently because "I have felt too sick and depressed."

***Medical history.*** Joshua had no significant medical history other than normal childhood illnesses prior to his HIV-positive diagnosis. According to Joshua, approximately 2 ½ years ago, he and three of his basketball buddies had a sexual encounter with two prostitutes when they were visiting a neighboring city to attend a pro basketball game. Currently, he is recovering from a bout of Pneumocystis pneumonia after spending 2 weeks in the hospital. He is still on medication for the pneumonia. Over the past 6 months he has lost 52 pounds. He is now at home and has slightly improved during the past few days, though he currently weighs only 86 pounds.

***Mental status.*** Joshua appeared agitated and restless, and was able to make eye contact only for short periods of time. During the initial contact he was teary eyed, admitted great fear, and expressed confusion and helplessness. He struggled to maintain his composure throughout the session. He was reluctant to talk about his sexual history, although he seemed quite willing to relate other information about his past. He expressed bitterness toward his family and friends for "avoiding me like the plague." There was no evidence of tangential thinking or suicidal ideation.

## APPROACHES TO PREVENTION

### Counselors as Educators

In the absence of an effective treatment or vaccine against HIV infection, risk reduction education programs must continue to be developed to restrict the spread of HIV/AIDS in adolescents such as Joshua. The goal of such programs is prevention of the spread of the virus through behavioral change. The ultimate goal is to eradicate HIV/AIDS in the same manner that society has eradicated other epidemics. The best weapon we have in this battle is education through teaching people about HIV/AIDS and, more important, teaching them to change their behavior. It is critical for counselors to expand the definition of counseling by accepting the responsibility to provide prevention education about HIV/AIDS. Education may be done with individuals, with families, in the schools, in community programs, or in whatever milieu teenagers are found.

In order to present effective prevention programming, counselors need to be both knowledgeable about AIDS-related issues and comfortable talking about sexuality. In a national survey of counselor education programs, 243 programs identified AIDS as high priority for inclusion in curricula. Yet nearly 40% of the responding programs did not include any AIDS training in their curricula (House, Eicken, & Gray, 1995). This lack of training suggests that many counselors entering the profession may not be prepared to assist clients with AIDS-related issues. It is essential that these counselors learn about HIV/AIDS through attending appropriate continuing education seminars and workshops.

Sexual comfort is the most important qualification of professionals who work with HIV/AIDS and adolescents. No matter how carefully organized HIV/AIDS curricula and outreach strategies are, embarrassed or fearful educators can inadvertently sabotage HIV/AIDS prevention efforts. Counselors are part of a larger American society that typically receives inaccurate sexual information and powerful negative messages about sexuality that impede talking comfortably about sex. Communication about sexual issues is frequently made difficult by the profound emotional impact that sexual vocabulary carries. Confusion also arises because sexual terms lack precision. Consequently, not only is effective communication with adolescents diminished but also HIV/AIDS educators may transfer negative emotional feelings to the youth with whom they work.

It is erroneous to assume that counselors have developed sexual comfort as part of their training. A recent survey of counselor education programs indicated that only 42% offered discrete sexual counseling courses. The majority of programs did not require sexuality courses for master's programs in counseling. No counselor education program surveyed indicated that sexual training for counselors was overemphasized (Gray, Eicken, & House, 1994).

Becoming sexually comfortable is an ongoing process both circular and interactive in nature. The sexually uncomfortable person sets an awkward professional atmosphere that invites inhibition. Conversely, success as an HIV/AIDS educator contributes to a positive self-concept. In order to work with adolescents and HIV/AIDS, counselors must consciously begin the process of increasing their own sexual comfort. This journey begins by actively addressing the factors likely to contribute to physical, mental, or emotional constraint in the role of HIV/AIDS educator and prevention specialist:

- inaccurate sexual knowledge;
- inaccurate knowledge about HIV/AIDS;
- lack of an explicit sexual vocabulary;
- limited practice in talking about sexuality and HIV/AIDS;
- lack of identification and resolution of personal sexual issues; and

- sexual values and biases (e.g., homophobia) that interfere with openness to alternative life styles for others.

## Prevention Via Counseling Individuals

As counselors work with adolescents in an HIV/AIDS prevention mode, they find at least two groups of adolescents: adolescents whose behavior is currently high risk, and those who may be concerned and anxious but whose behavior is not high risk. This second population is often referred to as the *worried well.*

Working with adolescents can take many forms. One model and an illustration of how counselors might use that model follow. The key to the effectiveness of applying the concepts in this individual counseling model is the personal approach of the counselor. Creating a comfortable environment is paramount. Both an understanding of the developmental issues that adolescents face and respect for adolescent culture are necessary.

### *Individual counseling model*

1. Provide *information* about HIV/AIDS;
2. Address the difficulties of implementing *safer sex plans;*
3. Introduce *assertiveness* techniques and methods for resisting peer pressure;
4. Respond to the emotional and psychological *confusion* surrounding sexual behaviors and relationship dynamics;
5. Work to build *self-esteem;*
6. Incorporate exploration about sexual *decision making;*
7. Utilize active counseling techniques, such as role-plays, so that adolescent clients can rehearse discussing safer sexual behavior and asserting *boundaries* with prospective partners;
8. Assist the adolescent client in exploring personal *values* in order to come to terms with similarities and differences between values of self and family of origin; and
9. *Refer* the adolescent client to community resources for assistance with medical, legal, and social service issues related to HIV/AIDS.

***Using the individual counseling model.*** The nine guidelines are incorporated into the counselor's responses to the adolescent. Sections of dialogues between a school counselor and adolescents in the same high school as Joshua illustrate:

1. **Information**

*Adolescent:* I heard that Joshua is dying from AIDS. I didn't know that he was gay.

*Counselor:* I'm glad that you are concerned about Joshua and about HIV/AIDS. However, HIV is not just a disease of the gay population. Anyone can get HIV if they put themselves at risk. If a person is sexually active, he or she needs to protect himself or herself by using condoms. (The counselor could provide a pamphlet with more information about HIV/AIDS and teens or refer to an appropriate community agency if providing direct information is not an option.)

2. **Safer sex plan**

*Adolescent:* I heard that Joshua did not use condoms with those prostitutes in the city. But, forget it, I'm not using condoms ... they are too stupid.

*Counselor:* At first it is hard to use condoms. What is stupid about them for you? (The counselor and client could discuss safer sex practices—or where to get safer sex information—keeping in mind that the less behavior the counselor asks someone to change the more likely the behavior change will occur. The key concept is "What is the least amount of change that will protect you from being at risk for HIV/AIDS?")

3. **Assertiveness**

*Adolescent:* Since hearing about Joshua, I think I want Steven to use a condom. But he says, "No f...ing way will I wear that raincoat on my dicky."

*Counselor:* It is sometimes hard to stand up for what you believe, when people you care about think differently. How about practicing some ways to tell Steven you really mean it about wearing a condom? (Skills, such as using "I" language, making eye contact, voice and tone level, and outcome clarification can be utilized when helping adolescents assert themselves.)

4. **Confusion**

*Adolescent:* Pam doesn't want to sleep with me anymore. She's afraid she will get sick like Joshua. But it feels so good to be with her.

*Counselor:* If sex is the source of the problem, what other ways can you be close to Pam? (A discussion might follow regarding relationships, especially the confusion that often exists between emotional closeness and sexuality.)

5. **Self-esteem**

*Adolescent:* I think maybe I deserve to get AIDS like Joshua. I've never been popular enough to have one real boy friend so I take who I can. Mary called me a royal sluthead the other day.

*Counselor:* Sounds like you don't like some of the ways you've been behaving with boys. We all do things we don't feel good about and things we do feel good about. Let's talk about when you feel good about yourself and when you don't.

6. **Decision making**

*Adolescent:* Some of the guys only go out with girls who—you know—do it. I don't know what to do anymore because of this AIDS thing that Joshua has.

*Counselor:* Making these decisions is not easy. It would be great if there was a right answer that I could give you. What is most important is to help you decide which sexual activities feel right for you and how to be responsible with your choices (The counselor might want to use the decision-making model—Table 4—or the listing of sexual activities model—Table 2—included in this chapter. These models speak to safer sex activities and emphasize that sexuality includes a broad range of activities, including abstinence, and is not limited to penile-vaginal intercourse.)

7. **Communication about safer sex and relationship boundaries**

   *Adolescent:* The speaker at the AIDS assembly said we're supposed to talk to our sexual partners about safer sex and other stuff. But what do you say? And what's this "other stuff"?

   *Counselor:* It is hard to talk about sex. This county health brochure is a place to start. Let's go over it together. Then we can talk (or you can talk to the health clinic staff) about the other stuff like your values, birth control, your feelings about the relationship, and you and your partner's sexual needs.

8. **Values**

   *Adolescent:* My mom thinks that I shouldn't be Joshua's friend because he has AIDS. But I like him better than any of the other kids on the basketball team.

   *Counselor:* It sounds like you and your mom have a difference in values. Sometimes people that we care about believe differently than we do. How can I help you talk to your mom about these differences? (This might lead into a discussion of personal and parental values and how we decide what is right for each of us.)

9. **Referral**

   *Adolescent:* I don't know quite how to tell you this, but I am worried that I might have AIDS like Joshua. Last week I slept over at a friend's house, and we messed around. That friend was with Joshua and the prostitutes.

   *Counselor:* I appreciate your honesty. I have the name of a confidential community clinic that kids can go to for information about HIV/AIDS and testing. Tell me more about your concerns.

## Working Directly With Families as a Preventative Measure

Although the majority of parents agree it is their responsibility to provide sexuality education to their children, they frequently feel ill prepared to do so. Similarly, parents often struggle with the complexities and specifics regarding HIV/AIDS education, even though they might want to be directly involved with their adolescents. It is important to recognize that working with parents, in order to help them effectively educate their own children, is an important role of the counselor.

Parent/adolescent education courses about HIV/AIDS are an appropriate and useful prevention measure. Classes in which mothers and adolescent daughters participate are currently a popular and effective way to enhance communication about sensitive issues like sexuality within families. This model has been extremely effective with younger children in that students need to have messages reinforced by their family members. Seemingly, the same holds true for HIV/AIDS education.

All formal AIDS education programs for adolescents—whether in the school, church, or community setting—should solicit parental input at all stages. Parents must be involved in not only the development of curricula but also the implementation. It is exciting to see school- and community-based AIDS educational programs where parents observe and participate in the educational process. AIDS prevention measures that build in homework assignments that encourage family communication are more likely to achieve the final goal: safer behavior that reduces HIV risk for adolescents.

## Prevention in the Schools

Most schools have been directly impacted by HIV/AIDS. Some, as in the case of Joshua, have a student who has been diagnosed HIV positive; others have students whose family members or friends have HIV or AIDS. Counselors need to take the lead in making sure that appropriate HIV/AIDS education is implemented in the schools. In addition to HIV/AIDS curricula, counselors can help organize activities such as HIV/AIDS awareness programs, school fundraisers for local prevention programs, and a school health resource center. A strategy that many organizations have found effective is to have HIV-positive persons tell their personal stories. Another, used by large city schools, is incorporating school health clinics on school campuses. Models for such endeavors can be found through contacting Advocates for Youth (see this chapter's National AIDS Resources List).

Former U.S. Surgeon General C. Everett Koop ("AIDS and ...," 1988) specifically called for schools to start frank discussions about sex and teach children about HIV/AIDS and its dangers at the lowest grade possible. Most state health departments have developed AIDS curricula for youth unique to the values and concerns of their geographical area. To achieve optimum effectiveness, HIV/AIDS curricula must include information that is age-specific and must be viewed in terms of a larger health context. For example, in a school setting such information could be included in a communicable disease or health education unit, which can be taught as part of a comprehensive K-12 health education curricula. Such programs must be geared toward adolescents' own needs, perceptions, fears, and concerns and be sensitive to the contemporary youth culture.

HIV/AIDS curricula may be viewed as five separate, yet interfacing, content areas: medical information, risky and safer sexual behaviors, common myths and misinformation, effective sexual decision-making skills, and effective sexual communication skills. Tables 1 through 5 present examples of the content that can be included in these topical areas. Other curricula examples can be found by contacting the Sexuality Information and Education Council of the United States (SIECUS) (see this chapter's National AIDS Resources List).

## Prevention in the Community

Building prevention programs in the community takes place through utilizing networker and advocacy processes. In the role of networker and advocate, we must be knowledgeable about the particular political issues the HIV/AIDS crisis poses. Typical political problems include lack of funding for research and social services, community values that prevent or thwart education about sexual issues, and religious and moral views that reject alternative life styles or sexual behaviors.

Some people believe that promotion of safer sex behaviors encourages sexual activity among adolescents. Others say that sex education belongs in the home, school, *and* community. It is safe to say that opinions are polarized regarding HIV/AIDS prevention for adolescents. All too evident is that some individuals have an intense emotional investment in their value position about HIV/AIDS and sex education. When working in the community setting, expecting opposition is realistic. Be prepared to counter it.

**Table 1 | HIV/AIDS Curricula: Medical Information**

The most recent medical information about HIV/AIDS includes four areas: cause, acquisition, treatment, and prevention. The questions that follow relate to the four areas and can be used in educating adolescents about HIV/AIDS.

- **What is acquired immune deficiency syndrome (AIDS)?**—AIDS is a disorder of the immune system in which the system is weakened and is unable to prevent life-threatening infections.
- **How is AIDS transmitted?**—The AIDS virus is spread by sexual contact, needle sharing, or, less commonly, through tainted transfused blood or its components. The virus may also be transmitted from infected mother to infant during pregnancy, birth, or shortly after birth through breast feeding.
- **How is AIDS not transmitted?**—The AIDS virus is not spread by casual contact such as hugging, kissing, holding hands, touching objects handled by an infected person, toilet seats, dishes, or telephones.
- **Who can get AIDS?**—Anyone who has unprotected sex with an infected person or who shares needles is at risk for HIV. This risk is increased by having multiple sexual partners.
- **Is there a test for AIDS?**—A blood test can usually identify the presence of antibodies to the AIDS virus. Consult your local AIDS project or state/county health division for the latest information.
- **Is there treatment for AIDS?**—There is no cure for HIV/AIDS. However, treatments for AIDS-associated infections are improving, and thus people are living longer with HIV/AIDS.

**Table 2 | HIV/AIDS Curricula: Risky and Safer Sexual Behavior**

It is important to include the latest available information about risky and safer sexual behavior in HIV/AIDS curricula for adolescents. Please consult your local or state health agency for the latest updates. When educating adolescents about the risky to safe behaviors identified in this table, the use of straightforward language is necessary.

- **Risky behaviors** include vaginal and anal intercourse without a condom; oral-anal contact (rimming); putting a hand or fist into vagina or anus (fisting); fingers, tongue, or penis touching the vagina during menstruation; sharing sex toys (e.g., vibrators); piercing the skin; sharing needles; oral sex without a condom; masturbation on open/broken skin.
- **Safer behaviors** include vaginal intercourse with a condom,* anal intercourse with a condom, oral sex on a man with a condom, oral sex on a woman.
- **Safe behaviors** include kissing if neither person has open cuts or sores, masturbation on healthy skin, touching, massage, fantasy, parallel masturbation, solitary masturbation, clothed body-to-body rubbing, consensual voyeurism, exhibitionism.
- **The safest behavior is abstinence from sexual contact.**

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***Use of the Condom:** It is only with the proper use of a condom that HIV transmission can be prevented. Condoms can break or slip off during sexual intercourse. There is a correct procedure for applying a condom. It is important to put the condom on the penis prior to any sexual contact. Applying the condom includes squeezing and holding the end of the condom while unrolling it over the entire erect penis. The man must withdraw the penis while still erect to prevent the condom from slipping off and leaking. Condoms must not be reused. Latex condoms are effective barriers against the virus; natural animal skin condoms are not effective. Extra protection is provided by latex condoms that have spermicidal jelly containing nonoxynol-9. If additional lubrication is used, it is important to avoid oil-based lubricants such as Vaseline, mineral oil, or cold cream. Oil-based lubricants can erode and create holes in the condom. A recommended option is the water-based lubricating jelly K-Y.

**Table 3 | HIV/AIDS Curricula: Common Myths and Misinformation**

It is critical for educators to dispel common myths and misinformation about HIV/AIDS. The following six myths typically are found in the adolescent population:

1. Only gay men and lesbians get HIV/AIDS.
2. Only the sexually promiscuous get HIV/AIDS.
3. Donating blood can result in HIV/AIDS.
4. Casual contact such as touching, sneezing, having a meal with or sharing eating utensils with someone who has HIV/AIDS, and sharing a bathroom or going to the same school with a person with HIV/AIDS can transmit the virus.
5. HIV/AIDS can be transmitted through saliva, sweat, and tears.
6. Alcohol and drugs do not increase the risk of contracting HIV/AIDS.

**Table 4 | HIV/AIDS Curricula: Sexual Decision-Making Model***

Effective sexual decision-making skills need to be taught in terms of a larger frame of personal values. The exercise in this table is one example of a sexual decision-making model for adolescents.

**Check any of the reasons listed below that you used in deciding to become involved in the following sexual behavior:**

________ I wanted to find out what it felt like.
________ I was sexually excited.
________ I wanted to be as experienced as my friends are.
________ I was talked into it.
________ I didn't really decide—it just sort of happened.
________ I felt it would make me feel more mature or adult.
________ My partner and I decided we were ready for it.
________ I felt it was about time I tried it.
________ My parents said it would be okay.
________ Other: ________________________________

**Check any of the reasons listed below that you used in deciding not to participate in the following sexual behavior:**

________ I was scared.
________ I didn't really like the person.
________ My parents would disapprove.
________ I wasn't sure how to do it.
________ I don't believe people my age should be doing that.
________ I wanted to wait until I was in love.
________ I was afraid of getting caught.
________ My partner wouldn't agree to it.
________ I was afraid of getting venereal disease.
________ I was afraid of getting HIV/AIDS.
________ I was afraid it would result in pregnancy.
________ Other: ________________________________

**Possible Sexual Behaviors and Life Styles**

- abstinence from all sexual activity
- holding hands
- hugging
- kissing
- french kissing
- cuddling and caressing
- breast fondling
- rubbing bodies to orgasm
- mutual masturbation
- parallel masturbation
- cunnilingus
- fellatio
- intercourse between the thighs
- intercourse between the breasts
- vaginal intercourse
- anal intercourse
- analingus (rimming)
- brachioproctic sex (fingers/fist in anus)
- sex toys

**Table 4 | Continued**

- sexual reading material
- pornography
- heterosexual involvement
- homosexual involvement
- bisexual involvement
- sex with strangers
- sex with more than one person at a time
- precommitment to partner sexual involvement
- monogamy
- serial monogamy
- use of condoms during oral sex
- use of condoms during vaginal sex
- use of condoms during anal sex
- birth control

*Adapted from Calderwood, 1983

For example, advocates must take into consideration the basic fundamentals of community change. The counselor must become familiar with the power structure of the community as well as lines of decision making within specific agencies or programs. Effective community involvement can make a difference between success and failure in addressing HIV/AIDS issues. All points of view must be represented before and during the development of a prevention program. This can be done, in part, by seeking participation from select members of the community who represent diverse populations. These members may disagree about the need for HIV/AIDS education, but at the same time they are willing to work toward common community goals. Including teenagers and parents is critical. Additionally, networking with other educators, regionally and nationally, who have successfully addressed controversy in their own communities provides a reference for strategic planning.

**Table 5 | HIV/AIDS Curricula: Sexual Communication Skills**

Effective sexual communication skills are critical for developing a healthy sexuality. Listed in this table are several areas that need to be talked about with a prospective partner prior to a sexual relationship. Counselors can use many creative methods to operationalize communication about these issues. Role-plays, fishbowls, mock advertisements, and use of art, dance, music, and film are among possibilities.

1. Feelings
2. Significance of the sexual encounter
3. Sexual preferences and needs
4. Birth control methods
5. Safer sex plans including abstinence

When talking with community members about building or expanding an HIV/AIDS prevention program, it is important to correct misunderstandings by providing the most current and accurate factual information about HIV/AIDS. Professionals can use statistics that speak specifically to their community. For example, in Joshua's community many of the citizens appear to believe that HIV/AIDS is predominantly a disease afflicting gay men. However, Joshua, like many other individuals, was infected via experimental, heterosexual contact. There are ample data indicating that heterosexual transmission, worldwide, is becoming the most common form of infection. Women, in particular, are becoming infected with HIV at an alarmingly rapid rate. These data are important so that parents with heterosexual children recognize the need to educate their children that HIV/AIDS does concern them.

Some community education experts (Cohen & Wiseberg, 1990; House & Walker, 1993) specifically mention that cooperation from churches is essential for effective community educational programs. Although some religious organizations have taken positions opposing HIV/AIDS education on moral grounds, others are willing and eager to participate in educational efforts. For example, the American Friends Service Committee, a Quaker organization, purports that withholding information about safer sexual behavior is immoral because of health implications. This is an important viewpoint to share.

Community members who are angry, confused, or anxious about HIV/AIDS deserve the help of professionals who are sensitive to local community concerns. Yet the public must recognize that the goal of HIV/AIDS prevention programs is to focus on health issues, not to get roadblocked by differing views of morality. Calamidas (1991) stressed:

> ...educators should not be intimidated into offering educational programs that are weakened in order to avoid controversy.... educators must emphasize that they are compelled to discuss all aspects of controversial and ethical issues, and it is imperative that they be allowed to freely answer all questions.... if educators acknowledge that values and value positions are inherent to the educational program and that the primary value of concern is *health*, controversy can be reduced. (pp. 56–57)

## INTERVENTION STRATEGIES

### Working With HIV Diagnosed Youth From a Family, School, and Community Model

The counselor needs to undertake multifaceted roles when working with an HIV-diagnosed youth. No singular intervention is effective. Different roles include, but are not limited to, intervening not only with HIV-positive adolescents but also their families, schools, and communities. A systems approach to intervention is critical. However, it is important for the counselor to be aware of conflicting responsibilities inherent in these roles.

Counseling the HIV/AIDS-diagnosed youth takes sensitivity and skill. The youth who has HIV/AIDS is facing a life-threatening illness, probable death, and stigmatization by some individuals in society. The teen is likely to be confused about the medical aspects of the disease. He or she may feel extremely guilt ridden and regretful about past sexual experiences or drug use. "For many young men, testing HIV positive may be even more devastating than for those who contracted the virus before scientists had even identified its existence" (Bull & Gallagher, 1994, p. 36). Other emotional responses of HIV-positive adolescents include fear, anger, denial, and pain.

The family of the HIV-positive adolescent is also struggling with its own set of issues. For example, Joshua's family consists of three brothers, ages 15, 14, and 11, and one sister, age 9. Joshua's siblings have all felt stigmatization and ostracism since their brother's diagnosis became public. They are aware that Joshua is very sick and may soon die. This possibility overwhelms both parents, and they have responded through withdrawal and verbal helplessness. Joshua's illness is incredibly frightening to each family member, and each has responded differently.

Further, an adolescent's school community is affected by an HIV-positive diagnosis. From the case study of Joshua, it is apparent that several other adolescents may be directly linked to the original HIV carrier. These adolescents, like Joshua, may have since had unprotected sexual experiences. Many of Joshua's classmates and their parents are reacting to the information that Joshua is ill with hostility and withdrawal. Teachers and administrators from Joshua's school are immobilized. There has been no organized response by the school to the panic exhibited by students and parents. The teachers struggle, from lack of experience and education, with how best to address their own feelings and those of the student body.

The community at large in which the HIV-positive youth lives needs attention. The counselor needs to be proactive with local community agencies to insure that Joshua receives the care and treatment to which he is entitled. As in the landmark case of one teenager, Ryan White, Joshua may need social, political, and legal advocacy to help him fight social injustices that impact adolescents with HIV/AIDS. (Ryan White contracted AIDS as a child from blood transfusions. He lived in Kokomo, Indiana, and was not allowed to continue enrollment in his local school.) Two very significant community problems relating to Joshua are the fence that has been erected by neighbors to keep them from "contracting this terrible disease" and the breach of confidentiality at the physician's office where Joshua was diagnosed.

Table 6 is one model of how to work with the adolescent with HIV/AIDS utilizing a multidimensional model for all components of the system. Remember that the suggested steps are not linear, and emphasis is dependent upon the relationship with a particular client and his or her family, school, and community. Therapeutic issues usually center around helping people find the personal strength and resources to cope with a positive diagnosis. The two most important aspects of counseling with a person who is HIV positive, and others affected by the illness, is a willingness to just be there as a compassionate listener and to advocate assertively for the rights of the individual with HIV/AIDS.

The following is an example of how the counselor might begin to respond to Joshua, the 17-year-old who is HIV positive. The guidelines from Table 6—assessing, educating, assisting, counseling—are used as the framework for counselor intervention.

## Assessing

Joshua is currently ill and is recovering from a serious bout of Pneumocystis pneumonia. He feels better for periods of time. His psychological stress is high; his core issues seem to be fear of death and abandonment as well as guilt about his sexual contact with two prostitutes. Currently, his emotional support systems are not strong. However, the possibility of building support exists with parents,

**Table 6 | Guidelines for Counseling the HIV/AIDS Diagnosed Youth: Utilizing a Multidimensional Model for All Components of the System**

- **Assessing**
  1. Degree of medical illness
  2. Degree of psychological stress
  3. Degree of social isolation and support systems
  4. Significant others and family responses
  5. Management of daily living
  6. Financial need.
- **Educating**
  1. Effects of the virus
  2. Health care, insurance, and Social Security issues
  3. Transmission of the virus
  4. Sexual activity options.
- **Assisting**
  1. Networking with social agencies
  2. Responding to employment, housing, and discrimination needs
  3. Developing support systems.
- **Counseling**
  1. Providing an emotionally caring atmosphere
  2. Confronting denial about the HIV/AIDS diagnosis
  3. Confronting rejection and stigma issues
  4. Addressing loss and grieving issues.
  5. Teaching stress identification and reduction techniques
  6. Bridging communication with friends and family.

siblings, former friends, and basketball teammates as well as teachers. Some of Joshua's daily needs are being met. For example, basic food and shelter are provided by his parents. He currently is receiving consistent health care from a family physician and an infectious disease specialist. More health services may be necessary, specifically home health care. The family's financial situation prior to the illness was tenuous and is further stretched by the high medical costs associated with HIV/AIDS.

### Educating

It is important that Joshua, his family, and other individuals understand the life cycle of HIV/AIDS and its related infections. With accurate information about HIV and its transmission processes, educated choices can be made. One reason for some of the emotional and relational rejection may be due to misinformation, particularly in the case of the neighbors who erected a fence to "keep the virus out" and the schoolmates who are not allowed to visit him. In addition, Joshua and his family need accurate information about the effects of medications Joshua is taking so that they can distinguish between side effects and the symptoms of the infections associated with HIV/AIDS. If they understand about the course of the virus, they will be able to make the most of the times when he is feeling better. Because there is a connection between physiological responses of the body and health habits, it is imperative that Joshua eat and sleep well.

### Assisting

Working with community agencies that can provide outside assistance for Joshua is essential. These agencies include, but are not limited to, local HIV/AIDS projects and county and state health departments. Frequently, services are duplicated and/or ignored due to lack of coordination. It is critical to help facilitate the effective use of multiple helping systems. For example, support groups usually exist for persons with HIV/AIDS, and volunteers are available to help with transportation and other practical needs. This kind of intervention will give Joshua opportunities to leave the house occasionally and relieve stress on his family as primary caregivers. The issues of medical expenses for the family and future hospitalization also need to be addressed through linking with appropriate agencies, such as Social Security, home health care, and legal aid. The counselor needs to network with health services to make sure that outreach contacts occur with the other boys from Joshua's school who also had sexual contact with the two prostitutes identified as most likely transmitting the virus to Joshua. Similarly, Joshua's girlfriends need to be contacted. It is likely that these particular adolescents are especially anxious and worried about having contracted HIV/AIDS themselves. The student body at large and the staff of the school may also have special needs due to public awareness of Joshua's diagnosis. For example, an aggressive HIV/AIDS education program should be implemented in the school to reduce unnecessary fear.

If Joshua is interested, efforts might be made to help him continue part-time employment at the library. This might include arranging with library personnel for Joshua to be allowed to bring library work home. The school needs to be contacted and a plan initiated so Joshua can continue his high school program. Special services of the school district should be identified. Tutoring Joshua to gain his high school diploma may be a viable option if attending school is not possible due to health limitations.

Although not fully functioning, Joshua's primary support system is his family. Family meetings should be held to work with the withdrawal patterns of his brothers and sister, the distancing of his father, and the helplessness of his mother. It might be important for the family to understand the caretaker role Joshua played as oldest sibling in the family, and the possible fear that family members associate with the prospect of losing that caretaker. The family needs to come to terms with the stigma that they associate with having a child/sibling who has HIV/AIDS. Family members must be assisted to recognize the critical part they play in supporting Joshua, and that their support is intrinsically connected to his well-being.

Other potential support systems for Joshua are the many female friends and athletic teammates at school. These two groups, and their parents, need special outreach efforts to reestablish positive relationships. Joshua's teachers, especially ones such as the computer specialist that he felt close to, also need to be utilized as potential support people.

## Counseling

When establishing a counseling relationship with Joshua, the counselor must be particularly emotionally supportive. It is important for the counselor to commit to a long-term counseling relationship with Joshua. The first step in the process is to assist Joshua in expressing his emotions in a safe and nonjudgmental setting. Joshua, seemingly, is experiencing many emotions, including regret and anger. In order to work with Joshua about these issues, creating a trusting bond is essential. The pain associated with his sense of emotional abandonment by his family and rejection by his friends must also be addressed. The counselor can help Joshua begin to face his diagnosis by encouraging him to grieve and deal with his many losses. Because research has suggested that increases in stress levels exacerbate the rate of HIV-related infections, the counselor is obligated to teach stress identification and stress reduction techniques or refer to appropriate professionals (e.g. licensed masseuse, biofeedback technician, nutritionist) (Moffatt, Spiegel, Parrish, & Helquist, 1989).

Family members may benefit from individual and/or family counseling as well. As parents or siblings, there may be feelings of shock, embarrassment, hurt, and anger. Seemingly simplistic questions may be present: what to say to other family members, friends, and neighbors? More complicated situations such as understanding medication regimens and interactive effects also are common for the family. The strain of a life-threatening illness is intense for everyone involved; and the strain frequently affects the family's other relationships.

## Ethical Issues in Counseling With the HIV/AIDS Adolescent

The development of HIV/AIDS and resulting deaths raise endless ethical questions for the counselor. According to Manuel et al. (1990), the literature surrounding HIV/AIDS and ethics can be divided into eight categories: (1) quarantine and isolation of HIV patients; (2) discriminatory measures concerning specific population groups; (3) nonrespect of the confidential nature of medical information; (4) application of the penal code; (5) screening, compulsory notification, and registration; (6) protection of blood given for transfusion; (7) research on drugs and vaccines; and (8) fundamental rights of the person with HIV/AIDS.

One primary ethical concern is confidentiality limits with the HIV/AIDS client who continues to be sexually active without informing his or her partner. The question that continues to be debated (Gray & Harding, 1988; Harding, Gray, & Neal, 1993) asks At what point, if any, do counselors breach a confidential relationship with a client who has the AIDS virus to preserve society's goals of health and safety? This ethical dilemma highlights the fine line between individual freedom and the health and welfare of society at large. As there is no dominant legal precedent to look to for guidance on this issue, it is likely that statutes vary from state to state (Harding, Gray, & Neal, 1993).

Limits of confidentiality in the counseling relationship have previously been defined in terms of "clear and imminent danger" (American Association for Counseling and Development [AACD], 1988) to the client or others, ordinarily seen in the context of client suicide and homicide. The American Counseling Association (ACA—formerly AACD) has added in its recently revised Code of Ethics (ACA, 1995) a specific statement on confidentiality and contagious, fatal diseases:

> A counselor who receives information confirming that a client has a disease commonly known to be both communicable and fatal is justified in disclosing information to an identifiable third party, who by his or her relationship with the client is at high risk of contacting the disease. Prior to making a disclosure, the counselor should ascertain that the client has not already informed the third party about his or her disease and that the client is not intending to inform the third party in the immediate future. (Section B.1.d.)

In addition, the ACA Code of Ethics continues to obligate counselors (in Section B.1.e) to "consult with other professionals when in doubt as to the validity of an exception" to the requirement for confidentiality. Thus counselors who find themselves struggling with issues surrounding counseling HIV/AIDS youth and confidentiality should also consult with other professionals as a part of their decision-making process.

### Counselors as Referral Agent

Referral can be utilized in a variety of circumstances surrounding HIV/AIDS and adolescents. One may be when counselors recognize that their own biases and values are interfering with delivering appropriate services, whether working at the individual, family, school, or community level. At this time it is critical for counselors to refer in a manner that does not negatively impact adolescents or their families. Another circumstance for referral may arise when a problem is so specialized that it requires unique assistance that the counselor cannot provide. Yet another circumstance is that working as personal counselor with an HIV-positive adolescent, his or her family, and significant others presents potential role conflicts.

It is important for counselors to be familiar with existing resources or how to find them. State, county, and community health departments have current information and services about HIV/AIDS and are considered a major information source. In addition, HIV/AIDS organizations that specifically focus on providing services, such as volunteer transportation and meals, are available in most large communities. Many national helping professional organizations, such as ACA, can provide guidance for locating appropriate resources. Advocates for Youth is one of the primary HIV/AIDS and adolescent resource centers that counselors should identify. The center provides bibliographies, curricular information, pamphlets, materials for parents, videos, and leader resources. The Centers for Disease Control and Prevention (CDC) provides updated statistics and medical information about HIV. The nonprofit organization Sexuality Information and Education Council of the United States (SIECUS) has the largest sexuality library in the United States and is rich in examples of HIV/AIDS curricula. These three organizations, and other resources, are listed at the end of this chapter.

## ADAPTATION FOR DIVERSITY

Curricula and counseling services must be accessible to people from a wide variety of cultural and ethnic backgrounds. HIV/AIDS does not exclude any culture, and neither should AIDS prevention curricula and intervention programs. In many cases, however, HIV/AIDS programs are developed for European American middle-class adolescents and their families. In this section we discuss some specific considerations for working with youth of color and the harder-to-reach youth.

## Working With Youth of Color

Youth of color are at higher risk for contracting HIV/AIDS, as indicated by the disproportionate percentage of Blacks and Hispanics affected by HIV infection and AIDS since the beginning of the epidemic. Intravenous drug use and other risk behaviors among low-income African Americans and Hispanics are most often attributed to the low income and resulting poverty of these groups (De Le Cancela, 1989; Mays & Cochran, 1988). Also, adolescent members of ethnic minority groups may know less and have more misconceptions and fear about AIDS than Whites. DiClemente, Boyer, and Morales (1988) stated that Black and Latino adolescents see themselves as susceptible to HIV/AIDS and thus have more anxiety about contracting the disease.

Further, minority teens have cultural or linguistic barriers that make it likely that standard educational programs will not work. Sensitivity to cultural values, religious beliefs, and social customs is needed in order to increase the likelihood that adolescents will understand and incorporate the information being conveyed to them. Social networks are powerful forces in both the African American and Hispanic cultures. Counselors should utilize these networks in preventive education and intervention programs. Showing family, relatives, and peers specific ways they can help reduce risk-taking behaviors in adolescents is an important strategy. Atwood (1993) proposed a systemic approach to behavior change with African American and Hispanic youth. Her approach, like this chapter's, views the adolescent as a member of a family, a school, a community, and also of the larger social system. Thus messages that focus on the adolescent as a responsible member of a family and a social network are more helpful than the individualistic message of "protect yourself."

Cross-age helping, where adolescents play an important role in the educational and social service enterprise as volunteer educators, is another important strategy when working with minority adolescents. Older adolescents can teach younger ones in any prevention program. Peer counseling groups can be established to discuss reasons for having sex (see Table 4). Reasons might include wanting to be loved, wanting to be accepted, needing closeness and nurturance, proving masculinity or femininity, participating in the rites of passage into maturity, wishing to conform to peer group expectations, rebelling against parents, curiosity, and needing to know whether they are sexually attractive and acceptable to members of the opposite sex (Atwood, 1993; Calderwood, 1983).

## Working With the Special Needs of the Harder-to-Reach Youth

Adolescents within the mainstream of the school system can benefit from traditional school-based HIV/AIDS education, but adolescents outside the school system need to be reached through specially designed programs. The harder-to-reach adolescent often is the poor student, the dropout, the homeless, the incarcerated youth, the runaway, the drug abuser, and the gay and bisexual youth.

Many of these adolescents are kicked out of their homes because their families are unable to accept their behavior, do not have money to support them, or believe they "cannot handle them." More than 1 million teenagers run away each year (Advocates for Youth, personal communication, August 1994). "Various community surveys and youth shelter data suggest that somewhere between 1 and 1.3 million adolescents are in emergency shelters or on the streets in any given year" (Athey, 1991, p. 518). These runaways are escaping stressful environments, and most often are victims of extremely dysfunctional families.

Street kids have been labeled *throwaways*. These adolescents engage in survival sex to meet financial needs. It is estimated that there are nearly 1 million adolescent prostitutes in the United States (Athey, 1991). It is clear from studies of homeless youth and from their risk behaviors that many are already HIV positive. Some are just discovering their HIV status, as many more homeless youth have been requesting tests at youth shelters (Athey, 1991).

Gay and bisexual males are currently and have always been the number 1 high-risk group for HIV/AIDS in the United States. It is generally thought that 10% of the adult population is gay; that means 1 out of every 10 children in a classroom will eventually identify themselves as gay. The gay youth is constantly pressured into a male-female life style by a society that assumes everyone is heterosexual. Gay youth have become one of the biggest subgroups that make up the street kid phenomenon. The pain and fear of struggling with sexual identity creates a lonely world not often shared with anyone. If the adolescents' gay orientation is known, often they lose their family and peer group support system.

More than a decade into the epidemic, it is clear that preventive strategies among gay youth are failing, and a second wave of HIV-positive youth is emerging. A 1993 report from the San Francisco Health Commission found that almost 12% of 20- to 22-year-old gay men surveyed were HIV positive, as were 4% of 17- to 19-year-olds. If those figures are not quickly reversed, health officials say, the current generation of young urban gay men will have as high an infection rate by the time they reach their mid-30s as middle-aged gay men are thought to have today—close to 50% (Bull & Gallagher, 1994, p. 38).

Unfortunately, educators are still unable to agree on what constitutes safer sex, leaving all adolescents, but gay youth in particular, unsure of exactly how to protect themselves. "Research is inconclusive about anal sex with condoms and unprotected oral sex. As a result, safer sex guidelines vary from city to city" (Bull & Gallagher, 1994, p. 38). What further complicates this situation is that educators disagree about whether AIDS prevention for gay youth should focus narrowly on safer sex practices or more broadly on issues of personal responsibility and relational dynamics. When love comes into the picture, it is easy to forget what is intellectually known about safer sex. "Contrary to what some conservative critics believe, research indicates that lust is not the only factor that incites unsafe sex among gay men" (Bull & Gallagher, 1994, p. 38).

Counselors must challenge their own heterosexual and/or homosexual assumptions. They must make a conscious effort to look for the children in the classroom and in community programs who are grappling with sexual identity issues. Listening to these children in a nonjudgmental fashion and helping them find support in their struggle is important. Counselors must help the gay youth face at least two major issues: isolation and possible rejection by family, and life-threatening illness as a result of unprotected sex. Through proactive and supportive interventions, such as acknowledgment that homosexuality is an acceptable life style, it is possible to meet the needs of these children. Consequently, this may prevent some of them from becoming runaways—and almost certainly contributing to the HIV/AIDS pandemic.

Abstaining from sex is not a realistic vision for many of the adolescents who are functioning in a survival mode. Emphasis needs to be placed upon outreach programs that move outside the classroom and into the streets. Counselors must be creative and develop prevention programs using whatever methods work to meet the special needs of the harder-to-reach youth. If the kids can not come to counselors, counselors must go to the kids. Workers from programs for runaway children in New York City cruise the streets until 5:00 a.m. each morning offering hot chocolate, sandwiches, and condoms. The language counselors use may need to be changed. Terms such as *intercourse* and *oral sex* may need to be thrown out the window for *fucking* and *sucking*. Along with professionalism, counselors must bring their own street smarts when talking to the kids if high-risk behavior for HIV/AIDS is going to be changed.

Other youth groups that are difficult to reach include the physically disabled, developmentally delayed, or mentally ill. Counselors cannot assume that these adolescents are refraining from sexual activity or drug use. These groups are frequently neglected in HIV/AIDS education efforts. Recently, sex education programs have designed programs that include these populations. Similarly designed programs should be considered when planning HIV/AIDS education programs for the physically disabled, developmentally delayed, or mentally ill youth.

## SUMMARY

This chapter emphasizes the importance of counselors working as prevention and intervention specialists with individuals, families, schools, and communities. Educational processes are stressed. It is a grave mistake, however, to assume that education equals factual information and that this, by itself, translates into behavioral change. Counselors must be progressive, compassionate, and creative. They must also apply reason to their work. They need to break through resistance to behavioral change because of strong, misguided, mind sets. Adolescents believe "this won't happen to me." Uninformed parents believe "only gay males and intravenous drug users contract HIV/AIDS." Bigots purport "people with AIDS are our modern day lepers." These irrational beliefs can no longer be tolerated.

Researchers are currently struggling to acquire the information and medical technology needed to develop a cure for HIV/AIDS. The outlook for a cure in the near future is not optimistic; some say we must learn to live with some form of HIV as long as there are human beings on this planet. Others say that even with a cure, elements such as poverty, racism, sexism, and homophobia will continue to contribute to the far-reaching consequences of HIV/AIDS. But as deep-seated and seemingly intractable are these problems are, they are not excuses for not going forward to the best of our abilities. We must continue our involvement in the social, psychological, political, legal, and ethical ramifications of HIV/AIDS. We are not powerless. We certainly have the skills and knowledge to impact the course of negative societal reactions. Most assuredly, we have the ability to help many adolescents change their behavior. Most of all we can provide and foster compassion for those youth diagnosed with HIV/AIDS. Assuming the responsibility of addressing HIV/AIDS is a counselor legacy worth remembering.

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## NATIONAL AIDS RESOURCES

**Advocates for Youth**
1025 Vermont Avenue, NW, Suite 200
Washington, DC 20005
(202)347-5700

Advocates for Youth (AY), a national education and advocacy organization, is dedicated to improving the quality of life for adolescents by preventing risk-taking behaviors and too-early childbearing. AY offers a variety of services, including training for youth services professionals, materials development and distribution, peer education, and technical assistance. The AY Resource Center maintains an extensive collection of materials, the focus of which is major journals including back issues on adolescent sexuality issues. The center also houses books and newspaper articles as well as a large video collection on topics such as HIV/AIDS, adolescents, pregnancy, and general family planning issues.

**AIDS Information Network**
32 North Third Street
Philadelphia, PA 19106
(215)922-5120

The AIDS Information Network (AIN), formerly the AIDS Library of Philadelphia, provides comprehensive, current information on all aspects of HIV/AIDS to anyone who wants it. The largest AIDS-related lending library designed for public use in the United States, the AIDS Information Network is one of the few AIDS organizations with a trained librarian on staff. The library provides referrals, a newsletter, general and specific information on HIV/AIDS, research assistance, displays, speakers, and bibliographies and resource listings.

**AIDS Project**
**American Civil Liberties Union Foundation**
132 West 43rd Street
New York, NY 10036
(212)944-9800, ext. 545

The AIDS Project of the American Civil Liberties Union (ACLU) Foundation undertakes litigation, public policy advocacy, and public education on civil liberties issues raised by the AIDS crisis. The project is headquartered in New York, staffed by four attorneys and two support personnel, and supplemented by a legislative expert in Washington, DC, and five ACLU affiliate attorneys whose efforts focus on HIV/AIDS-related issues.

**American Foundation for AIDS Research**
733 Third Avenue, 12th Floor
New York, NY 10017
(212)682-7440
The American Foundation for AIDS Research (AmFAR) is the nation's leading nonprofit organization dedicated to the support of HIV/AIDS research, education, prevention, and sound public policy. AmFAR identifies unmet needs in HIV/AIDS biomedical research (including clinical research), the social sciences, education for prevention, and public policy development. The foundation has provided nearly $58 million to innovative projects in these vital areas. In support of scientific research, AmFAR selects innovative proposals and approaches, and awards grants in basic science, social research, clinical research, public policy, and education.

**CDC National AIDS Clearinghouse**
P.O. Box 6003
Rockville, MD 20849-6003
(800)458-5231
The Centers for Disease Control and Prevention (CDC) National AIDS Clearinghouse (NAC) is a national reference, referral, and publication distribution service for AIDS and HIV information. CDC NAC is a comprehensive information service for public health professionals, educators, social service workers, attorneys, human resource managers, and employers. Information services are provided by telephone or mail. The clearinghouse maintains several computerized databases, which reference specialists with a broad knowledge of AIDS organizations and materials access to answer inquiries, make referrals, and help locate publications about HIV infection and AIDS.

**CDC National AIDS Hotline**
P.O. Box 13827
Research Triangle Park, NC 27709
(800)342-AIDS
The Centers for Disease Control and Prevention (CDC) National AIDS Hotline provides current and accurate information about HIV infection and AIDS to the general public. Callers access the hot line any time, day or night, to receive information. The hot line provides callers with descriptive information about HIV and AIDS; confidential information about preventing and reducing the risk of transmitting HIV infections; information about counseling, testing, and support services; referrals for local legal, financial, and treatment resources; and HIV/AIDS publications.

**Gay Men's Health Crisis**
129 West 20th Street
New York, NY 10011-0022
(212)337-3553
The Gay Men's Health Crisis (GMHC) is a community-based, volunteer AIDS service organization that pursues a three fold mission: services, education, and advocacy for people whose lives are affected by HIV. GMHC provides individual and group support, financial advocacy, recreational opportunities, and crisis intervention services. Legal services are provided to ensure that people with HIV infection can live full, productive lives in the face of possible legal difficulties. GMHC uses many avenues in addition to a hot line to reach its audiences: publications, videos, safer sex workshops, outreach into communities of color, information tables on city streets, distribution of condoms and safer sex guidelines to bars and clubs, and educational programs for mental health professionals and employers.

**Hemophilia and AIDS/HIV Network for the Dissemination of Information**
**The National Hemophilia Foundation**
110 Greene Street, Suite 303
New York, NY 10012
(212)431-8541
As the HIV/AIDS information center of the National Hemophilia Foundation (NHF), the Hemophilia and AIDS/HIV Network for the Dissemination of Information (HANDI) is the hemophilia community's link to available resources dealing with hemophilia and HIV. HANDI provides information, resources, and referrals on hemophilia and HIV/AIDS to people with hemophilia, their families, and the professionals who care for them as well as to NHF chapters, other hemophilia organizations, and the general public.

**Kupona Network**
4611 South Ellis Avenue
Chicago, IL 60653
(312)536-3000
The Kupona Network of diverse programs is committed to providing education and support for HIV/AIDS-related issues affecting the Black/African American community. Kupona's mission is to provide realistic and culturally sensitive services to people living with HIV, their family members and friends, and the community.

**Multicultural Training Resource Center**
**Multicultural AIDS Resource Center**
1540 Market Street, Suite 320
San Francisco, CA 94702

(415)861-2142
The Multicultural Training Resource Center (MTRC) of San Francisco was established in 1984 as the first national center to provide multicultural and culturally specific HIV/AIDS and substance abuse prevention services. MTRC views multiculturalism as a concept that celebrates culture and cultural differences without limiting its definition to race, ethnicity, and color, thereby including women, the elderly, lesbians, homosexuals, and the homeless.

**National Association of People With AIDS**
1413 K Street, NW, Eighth Floor
Washington, DC 20005
(202)898-0414
The National Association of People with AIDS (NAPWA) serves as a national voice for all those infected and affected by HIV/AIDS. Funded by the Centers for Disease Control and Prevention, private corporations, other donors, and membership fees, NAPWA achieves its mission through three mechanisms: (1) information dissemination, (2) public policy advocacy, and (3) technical assistance to organizations. NAPWA's primary requesters are people with HIV/AIDS and related AIDS service organizations, including NAPWA's affiliate people with AIDS coalitions.

**National Coalition of Hispanic Health and Human Services Organizations**
1501 16th Street, NW
Washington, DC 20036
(202)387-7000
The mission of the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO) is to improve the health and well-being of all Hispanic communities in the United States by conducting national demonstration programs, coordinating research, and serving as a source of information, technical assistance, and policy analysis. COSSMHO addresses HIV/AIDS in the Hispanic community through the Community HIV and AIDS Technical Assistance Network (CHATAN), which provides technical assistance on the local, state, regional, and national levels by identifying, implementing, and assessing culturally appropriate intervention strategies.

**National Leadership Coalition on AIDS**
1730 M Street, NW, Suite 905
Washington, DC 20036
(202)429-0930
The National Leadership Coalition on AIDS is a membership organization of corporations, businesses, labor organizations, key trade and nonprofit organizations, and interested individuals that are dedicated to the HIV/AIDS education and prevention needs of small- and medium-sized businesses and minority employers and workers. The coalition fights the spread of HIV by promoting and

assisting workplace initiatives, including prevention and education programs that promote nondiscriminatory policies toward those living with HIV. Outreach and technical assistance efforts are tailored to specific industries, geographic locations, and trade associations.

**National Native American AIDS Prevention Center**
3515 Grand Avenue, Suite 1200
Oakland, CA 94610
(510)444-2051
The National Native American AIDS Prevention Center (NNAAPC) is directed and managed by and for American Indians, Alaskan natives, and Hawaiian natives. NNAAPC operates a national, toll-free, Indian-specific, AIDS hot line and a clearinghouse for native-specific HIV/AIDS and sexually transmitted disease information. The center also publishes a quarterly newsletter, *Seasons*.

**National Pediatric HIV Resource Center**
**Children's Hospital of New Jersey**
15 South Ninth Street
Newark, NJ 07107
(201)269-8251
The National Pediatric HIV Resource Center (NPHRC) serves professionals who care for children and families with HIV infection and AIDS. The center, funded in part by the Maternal and Child Health Bureau of the Health Resources and Services Administration, offers consultation, technical assistance, and training for medical, social service, and planning personnel. The center is staffed by professionals including a physician, nurse, psychologist, and social worker, and it receives numerous requests for assistance from providers working with HIV-infected children as well as from the general public. Consultation is provided to organizations designing new programs and modifying existing ones to serve children, youth, and families with HIV. Technical assistance is provided in areas such as developing family education materials, conducting needs assessments, evaluating programs, and designing systems of care that are family centered, community based, and culturally competent. Training and clinical fellowships are available to physicians, nurses, social workers, mental health professionals, and other providers.

**National Resource Center on Women and AIDS**
**Center for Women Policy Studies**
2000 P Street, NW, Suite 508
Washington, DC 20036
(202)872-1770
The Center for Women Policy Studies established the National Resource Center on Women and AIDS to fill the vacuum in public policy discussion of

HIV/AIDS and to address, from women's perspectives, critical policy issues for women of color and low-income women related to the AIDS crisis. A centralized information resource for researchers, policymakers, advocates, and caregivers, the resource center annually publishes the *Guide to Resources on Women and AIDS*, with a state-by-state directory of programs serving women and case studies of exemplary programs. The center develops policy options to ensure that women's needs are met in biomedical and behavioral research, clinical trials of AIDS treatments, development of HIV prevention strategies and risk-reduction education, and delivery of health care and social services.

**National School Boards Association**
**HIV/AIDS Education Project**
1680 Duke Street
Alexandria, VA 22314
(703)838-6722
Funded by the Centers for Disease Control and Prevention, the HIV/AIDS Education Project of the National School Boards Association (NSBA) helps school board members, superintendents, and other school-affiliated personnel to deal effectively with the issues of HIV and AIDS in schools.

**Planned Parenthood Federation of America**
810 Seventh Avenue
New York, NY 10019
(212)541-7800
The Planned Parenthood Federation of America (PPFA) is a federation of 168 nonprofit affiliates operating 922 clinics in 49 states and the District of Columbia. The affiliates provide reproductive health care and sexuality education to nearly 5 million men and women each year. Services include contraception, abortion, sterilization, and infertility services. PPFA also sponsors and advocates biomedical, socioeconomic, and demographic research regarding reproductive health issues. PPFA produces educational materials, acts as a clearinghouse, and provides community education through the affiliates. Most PPFA affiliates offer anonymous or confidential HIV testing and counseling to clients. All affiliates provide HIV educational materials, safer sex counseling, and referral services.

**Project Inform**
1965 Market Street, Suite 220
San Francisco, CA 94103
(415)558-8669
The three main goals of Project Inform are (1) to inform those infected by HIV (or at risk of infection) of lifesaving strategies such as early diagnosis and early intervention, (2) to give people and their health care providers the means to make informed choices about the most promising treatment options, and (3) to change research and regulatory polices that delay or prevent access to treat-

ment. Anyone can call the toll-free Treatment Hotline for up-to-date HIV treatment information.

**Sex Information and Education Council of the United States**
130 West 42nd Street, Suite 2500
New York, NY 10036
(212)819-9770

The Sex information and Education Council of the United States (SIECUS) was founded to provide health care professionals, educators, policymakers, students, and ethnic minorities with information and education on family life and related issues. SIECUS provides information to more than 12,000 people a year, serving all populations and racial and ethnic minorities. SIECUS' Mary S. Calderone Library provides library and information services by telephone or mail and in person at SIECUS headquarters in New York City. The library contains a unique collection of 5,000 sexuality-related resources, of which about 10% are related to HIV and AIDS. The AIDS collection comprises books, current journal articles, HIV/AIDS-related newsletters, and vertical files. The library is open by appointment for SIECUS members; information requests are accepted by telephone and mail.

# 11

# "I Don't Want to Live": The Adolescent at Risk for Suicidal Behavior

*David Capuzzi and Douglas R. Gross*

The adolescent at risk for suicidal preoccupation and behavior has become an increasing concern for schools and communities throughout the United States. Between 1960 and 1988 the suicide rate among adolescents increased much more dramatically than in the general population, rising by 200% compared to approximately 17% (Garland & Zigler, 1993).

The topic of adolescent suicide has been a major focus for newspaper features, television specials, and legislative initiatives as the problem of adolescent suicide has reached epidemic proportions (Hafen & Frandsen, 1986). Estimates such as "7,000 teenagers each year commit suicide, while an additional 400,000 try unsuccessfully to end their own lives" (Hafen & Frandsen, 1986) are based on incomplete data (Curran, 1987) yet provide the basis for ranking suicide as the second leading cause of death among the 11- to 24-year-old age group. According to some experts (Hafen & Frandsen, 1986), one teenager attempts suicide every 90 seconds and one completes the act of suicide every 90 minutes.

## PROBLEM DEFINITION

### Ethnic and Gender Differences

The suicide rate is higher among adolescent males than among females (although adolescent women attempt three to four times as often as adolescent men). Caucasian, adolescent males complete suicide more often than any other ethnic group. A number of explanations for the differences in rates between genders and races have been proposed, but no clear answers have been found. As early as 1954 (Henry & Short), an explanation based on a reciprocal model of suicide and homicide was suggested in which some groups were seen as more likely to express frustration and aggression inwardly and others were more likely to express it outwardly. Empirical data, however, do not support this reciprocal relationship. Some models used to explain racial differences in suicide have suggested that the extreme stress and discrimination that African Americans in this country confront helps to create protective factors, such as extended networks of social support, that lower the risk (Bush, 1976; Gibbs, 1988).

Native Americans have the highest adolescent suicide rates of any ethnic group in the United States, with considerable variability across tribes. The Navajos, for example have suicide rates close to the national average of 11 to 13 per 100,000 of the population; some Apache groups have rates as high as 43 per 100,000 (Berlin, 1987). The high suicide rates in the Native American population have been associated with factors such as alcoholism and substance abuse, unemployment, availability of firearms, and child abuse and neglect (Berman & Jobes, 1991). In general, less traditional tribes have higher rates of suicide than more traditional tribes (Wyche, Obolensky, & Glood, 1990).

## Methods

The use of firearms outranks all other methods of completed suicides; firearms are now being used by both genders. The second most common method is hanging, and the third most common is gassing. Males use firearms and hanging more often than females but females use gassing and ingestion more often than males for completed suicides (Berman & Jobes, 1991). The most common method used by suicide attempters is ingestion or overdose.

## Risk Factors

As noted by Garland & Zigler (1993), the search for the etiology of suicide spans many areas of study. Risk factors that have been studied include neurotransmitter imbalances and genetic predictors, psychiatric disorders, poor self-efficacy and problem-solving skills, sexual or physical abuse, concerns over sexual identity or orientation, availability of firearms, substance abuse, violent rock music, divorce in families, unemployment and labor strikes, and phases of the moon. It is important to note that almost all adolescent suicide victims have experienced some form of psychiatric illness. The most prevalent psychiatric disorders among completed adolescent suicides appear to be affective disorders, conduct disorder or antisocial personality disorder, and substance abuse (Shaffer, 1988). Among affective disorders, particular attention should be paid to bipolar illness and depressive disorder with comorbidity, such as attention deficit disorder, conduct disorder, or substance abuse (Rohde, Lewinsohn, & Seeley, 1991).

The suicide of a family member or a close friend of the family can also be a risk factor for adolescent suicide. Adolescents experiencing a physical illness that is chronic or terminal can also be at higher risk (Capuzzi, 1994). Many researchers have studied cognitive and coping style factors, such as generalized feelings of hopelessness and poor interpersonal problem-solving skills, as risk factors for adolescent suicide (Garland & Zigler, 1993). The best single predictor of death by suicide seems to be a previous suicide attempt (Shaffer, Garland, Gould, Fisher, & Trautman, 1988). Some studies have indicated that as many as 40% of attempters will make additional suicide attempts and as many as 10 to 14% of these individuals will complete suicide (Diekstra, 1989).

## Precipitants

Completed suicide is often precipitated by what, to the adolescent, is interpreted as a shameful or humiliating experience (e.g., failure at school or work, interpersonal conflict with a romantic partner or parent). The humiliation and frustration experienced by some adolescents struggling with conflicts connected with their sexual orientation may precipitate suicidal behavior (Harry, 1989), although being gay or lesbian, in and of itself, may not be a risk factor for suicide (Blumenthal, 1991). Hoberman and Garfinkel (1988) found the most common precipitant of suicide in a sample of 229 youth suicides to be an argument with a boy friend, a girl friend, or a parent (19%) followed by school problems (14%). Other humiliating experiences, such as corporal punishment and abuse, also serve as precipitants; the experience of sexual or physical assault seems to be a particularly significant risk factor for adolescent women (Hoberman & Garfinkel, 1988).

## Understanding the Myths

The biggest problem connected with the topic of adolescents at-risk for suicide may be that parents, teachers, mental health professionals, and adolescents themselves are not aware of the many myths and misconceptions as well as the signs and symptoms associated with adolescent suicide. The focus here is on the myths; recognizing the behaviors and other cues is discussed in a following section. Some of the most commonly cited myths and misconceptions (Capuzzi, 1988, 1994), which must be dispelled before effective prevention, crisis management, and postvention services can be initiated, include the following:

***Myth: Adolescents who talk about suicide never attempt suicide.*** This is one of the most widely believed myths. The reality is that all suicidal adolescents make attempts (either verbally or nonverbally) to let a friend, parent, or teacher know that life seems to be too difficult to bear. Because a suicide attempt is a cry for help to identify options, other than death, to decrease the pain of living, always take verbal threats seriously. Never assume such threats are only for the purpose of attracting attention or manipulating others. It is better to respond and enlist the aid of a professional than it is to risk the loss of a life.

***Myth: Suicide happens with no warning.*** Suicidal adolescents leave numerous hints and warnings about their suicidal ideations and intentions. Clues can be verbal or in the form of suicidal gestures, such as taking a few sleeping pills, becoming accident prone, and reading stories focused on death and violence. Quite often, the social support network of the suicidal adolescent is small. As stress escalates and options, other than suicide, seem few, suicidal adolescents may withdraw from an already small circle of friends, thus making it more difficult for others to notice warning signs.

***Myth: Adolescents from affluent families attempt or complete suicide more often than adolescents from poor families.*** This is a myth. Suicide is evenly spread among socioeconomic groups.

***Myth: Once an adolescent is suicidal, he or she is suicidal forever.*** Most adolescents are suicidal for a limited period of time. In our experience, the 24- to 72-hour period around the peak of the crisis is the most dangerous. If counselors and other mental health professionals can monitor such a crisis period and transition the adolescent into long-term counseling/therapy, the possibility is strong that there will never be another suicidal crisis. The more effort that is made to help an adolescent identify stressors and develop problem-solving skills during this postsuicidal crisis period, the more time that passes, the better the prognosis.

***Myth: If an adolescent attempts suicide and survives, he or she will never make another attempt.*** There is a difference between an adolescent who experiences a suicidal crisis but does not attempt suicide, as in the preceding discussion, and the adolescent who actually makes an attempt. An adolescent who carries through with an attempt has identified a plan, has access to the means, and has maintained a high enough energy level to follow through. He or she may believe that a second or third attempt may be possible. If counseling/therapy has not taken place or has not been successful during the period following an attempt, additional attempts may be made. Most likely, each follow-up attempt has a greater chance of becoming lethal.

***Myth: Adolescents who attempt or complete suicide always leave notes.*** Only a small percentage of suicidal adolescents leave notes. This is a common myth—and one of the reasons why many deaths are classified and reported as accidents by friends, family members, physicians, and investigating officers when what has actually taken place is suicide.

***Myth: Most adolescent suicides happen late at night or during the predawn hours.*** This is not true. Most suicidal adolescents actually want help. Thus most attempts are made mid to late morning and mid to late afternoon because a family member or friend is more likely to be around to intervene than would be the case late at night or very early in the morning.

***Myth: Never use the word suicide when talking to adolescents because using the word gives some adolescents the idea.*** This is simply not true. No one can put the idea of suicide into the mind of an adolescent who is not suicidal. If an adolescent is suicidal, using the word can instead help the adolescent verbalize feelings of despair and assist with establishing rapport and trust. If a suicidal adolescent thinks others know he or she is suicidal and realizes they are afraid to approach the subject, it can bring the adolescent closer to the point of making an attempt by contributing to feelings of despair and helplessness.

***Myth: Every adolescent who attempts suicide is depressed.*** Depression is a common component of the profile of a suicidal adolescent, but depression is not always a component. Many adolescents simply want to escape their present set of circumstances and do not have the problem-solving skills to cope more effectively, lower stress, and work towards a more promising future.

***Myth: Suicide is hereditary.*** Suicide tends to run in families, just as physical and sexual abuse does—which has led to the development of this myth. The tendency to suicide is not genetically inherited. Members of families do, however, share the same emotional climate because parents model coping and stress management skills as well as high or low levels of self-esteem. The suicide of one family member tends to increase the risk among other family members that suicide will be viewed as an appropriate way to solve a problem or set of problems.

Note, however, that endogenous depression can be inherited. Because of the connection between depression and suicide, many have mistakenly come to the belief that suicide can be genetically inherited.

## RECOGNIZING THE PROFILE

Many experts (Capuzzi, 1994; Capuzzi & Golden, 1988; Curran, 1987; Davis, 1983; Hafen & Frandsen, 1986; Hussain & Vandiver, 1984; Johnson & Maile, 1987) believe that about 90% of the adolescents who complete suicide (and first attempts can result in completions) give cues to those around them in advance. Whether these cues or hints are limited or numerous depends on the adolescent because each adolescent has a unique familial and social history. It is important for adults (and young people as well) to recognize the signs and symptoms to facilitate intervention. A comment such as "I talked with her a few days ago and she was fine—I am so shocked to learn of her death" may mean that no one was aware of the warning signs. One of the essential components of any staff development effort is teaching the profile of the suicidal or potentially suicidal adolescent so that referral and intervention can take place. Behavioral, verbal, and cognitive cues, and personality traits delineate the profile.

## Behavioral Cues

***Lack of concern about personal welfare.*** Some adolescents who are suicidal may not be able to talk about their problems or give verbal hints that they are at risk for attempting suicide. Sometimes such adolescents become unconcerned with their personal safety in the hopes that someone will take notice. Experimenting with medication, accepting dares from friends, reckless driving, and carving initials into the skin of forearms are possible ways of gesturing, of letting others know "I am in pain and don't know how to continue through life if nothing changes."

***Changes in social patterns.*** Relatively unusual or sudden changes in an adolescent's social behavior can provide strong cues that such a young person is feeling desperate. A cooperative teenager may suddenly start breaking the house rules that parents have never had to worry about enforcing. An involved adolescent may begin to withdraw from activities at school or end long-term friendships with school and community peers. A stable, easy-going teenager may start arguing with teachers, employers, or other significant adults with whom prior conflict was never experienced. Such pattern changes should be noted and talked about with an adolescent who does not seem to be behaving as he or she usually has in the past.

***A decline in school achievement.*** Many times, adolescents who are becoming more and more depressed and preoccupied with suicidal thoughts are unable to devote the time required to complete homework assignments and maintain grades. If such an adolescent has a history of interest in the school experience and has maintained a certain grade point average, loss of interest in academic pursuits can be a strong indication that something is wrong. The key to assessing such a situation is the length of time the decline lasts.

***Concentration and clear thinking difficulties.*** Suicidal adolescents usually experience marked changes in thinking and logic. As stress and discomfort escalate, logical problem solving and option generation become more difficult. As reasoning and thinking become more confused and convoluted, staying focused on suicide as the only solution is easier and easier. "It may become more and more obvious that the adolescent's attention span is shorter and that verbal comments bear little relationship to the topic of a conversation" (Capuzzi, 1988, p. 6).

***Altered patterns of eating and sleeping.*** Sudden increases or decreases in appetite and weight, difficulty with sleeping, or wanting to sleep all the time or all day can all be indicative of increasing preoccupation with suicidal thoughts. These altered patterns can offer strong evidence that something is wrong and that assistance is required.

***Attempts to put personal affairs in order or to make amends.*** Once a suicide plan and decision have been reached, adolescents often make last-minute efforts to put their personal affairs in order. These efforts may take a variety of directions: attempts to make amends in relation to a troubled relationship, final touches on a project, reinstatement of an old or neglected friendship, giving away prized possessions (skis, jewelry, compact discs, collections).

***Use or abuse of alcohol or drugs.*** Sometimes troubled adolescents use or abuse alcohol or other drugs to lessen their feelings of despair or discontent. Initially, they may feel that the drug enhances their ability to cope and increases feelings of self-esteem. Unfortunately, the abuse of drugs decreases ability to communicate accurately and problem solve rationally. Thinking patterns become more skewed, impulse control lessens, and option identification decreases. Rapid onset of involvement with illicit or over-the-counter drugs is indicative of difficulty with relationships, problem solving, and ability to share feelings and communicate them to others.

***Unusual interest in how others are feeling.*** Suicidal adolescents often express considerable interest in how others are feeling. Because they are in pain, but may be unable to express their feelings and ask for help, they may reach out to peers (or adults) who seem to need help with the stresses of daily living. Such responsiveness may become a full-time pastime, lessen preoccupation with self, and serve as a vehicle for communicating, "I wish you would ask me about my pain" or "Can't you see that I need help too?"

***Preoccupation with death and violence themes.*** Reading books or poetry in which death, violence, or suicide is the predominating theme can become the major interest of an adolescent who is becoming increasingly preoccupied with the possibility of suicide. These adolescents may be undecided about the possibility of choosing death over life and may be using the reading to work through various aspects of a decision. Other examples of preoccupation include listening to music that is violent, drawing or sketching that emphasizes destruction, watching movies that emphasize destruction of self and others, or writing short stories focused on death, dying, and loss.

***Sudden improvement after a period of depression.*** Suicidal adolescents often fool parents, teachers, and friends by appearing to be dramatically improved, after a period of prolonged depression, in a very short period of time. This improvement, which can sometimes take place overnight or during a 24-hour period, encourages friends and family who interpret such a change as a positive sign. But such a change often is the result of a suicide decision and the formulation of a concrete suicide plan on the part of the adolescent at risk. It may mean that the suicide attempt (and the potential for completion) is imminent and that the danger is peaking. Family and friends must remember that it is not logical for a depression to lessen that rapidly. It takes time, effort, and, at times, medical assistance to improve coping skills and lessen feelings of depression, just as it took time (months or years) to develop nonadaptive responses to people and circumstances and feelings of hopelessness.

***Sudden or increased promiscuity.*** An adolescent often experiments with sex during periods of suicidal preoccupation in an attempt to refocus attention or lessen feelings of isolation. Unfortunately, doing so sometimes complicates circumstances because of an unplanned pregnancy or an escalation of feelings of guilt.

## Verbal Cues

As noted by Schneidman, Farbverow, and Litman (1976), verbal statements can provide cues to self-destructive intentions. Such statements should be assessed and considered in relation to behavioral signs, changes in thinking patterns, motivations, and personality traits. There is no universal language or style for communicating suicidal intention. Some adolescents openly and directly say something like "I am going to commit suicide" or "I am thinking of taking my life." Others are far less direct and make statements such as "I'm going home," "I wonder what death is like," "I'm tired," "She'll be sorry for how she has treated me," or "Someday I'll show everyone just how serious I am about some of the things I've said."

When someone says something that could be interpreted in a number of ways, counselors, parents, teachers, and friends need to remember that it is always best to ask for clarification. Making assumptions about what a statement means or minimizing the importance of what is being communicated is not a good idea. Suicidal adolescents often have a long-term history of difficulty with communicating feelings and asking for support. Indirect statements may be made in the hopes that someone will respond with support and interest and provide or facilitate a referral for professional assistance.

## Cognitive Cues

Thinking patterns and motivations of suicidal adolescents provide cognitive cues that can also be assessed and evaluated. To make such an assessment, we need to encourage self-disclosure to learn about changes in an adolescent's cognitive abilities, including distortions of logic and problem-solving ability. As noted by Velkoff and Huberty (1988), the motivations of suicidal adolescents can be understood more readily when suicide is viewed as fulfilling one of three primary functions: (1) an avoidance function, which protects the individual from the pain perceived to be associated with a relationship or set of circumstances; (2) a control function, which enables an adolescent to believe he or she has gained control of someone or something thought to be out of control, hopeless, or disastrous; and (3) a communication function, which lets others know that something is wrong or that too much pain or too many injuries have been accumulated.

Suicidal adolescents often distort their thinking patterns in conjunction with the avoidance, control, and communication functions, so that suicide becomes the best or only problem-solving option. Such distortions can take a number of directions. All-or-nothing thinking, for example, can enable an adolescent to view a situation in such a polarized way that the only two options seem to be continuing to be miserable and depressed or carrying out a suicide plan; no problem-solving options to cope with or overcome problems may seem possible (Capuzzi, 1988).

Identifying a single event and then applying it to all events, or overgeneralization, is another cognitive distortion. For example, being left out of a party or trip to the mountains with friends may be used as evidence for being someone no one likes, a loser, or someone who will always be forgotten or left out. "I can't seem to learn the material for this class very easily" becomes "I'm never going to make it through school" or "I'll probably have the same difficulties when I start working full time."

Adolescents who are experiencing stress and pain and who are becoming preoccupied with suicidal thoughts often experience more and more cognitive distortions. The result is self-talk that becomes more and more negative and more and more supportive of one of the following motivations for carrying through with a suicide plan:

- wanting to escape from a situation that seems (or is) intolerable (e.g., sexual abuse, conflict with peers or teachers, pregnancy);
- wanting to join someone who has died;
- wanting to attract the attention of family or friends;
- wanting to manipulate someone else;
- wanting to avoid punishment;
- wanting to be punished;
- wanting to control when or how death will occur (an adolescent with a chronic or terminal illness may be motivated in this way);
- wanting to end a conflict that seems unresolvable;
- wanting to punish the survivors; and
- wanting revenge.

## Personality Traits

As noted by Capuzzi (1988), it would be ideal if research on the profile of the suicidal adolescent could provide practitioners with such a succinct profile of personality traits that teenagers at risk for suicide could be identified far in advance of any suicidal risk. Adolescents who fit the profile could then be assisted through individual and group counseling and other means. Although no consensus has yet been reached on the typical constellation of personality traits in the suicidal adolescent, researchers have nevertheless agreed on a number of characteristics that seem to be common to many suicidal adolescents.

***Low self-esteem.*** Several studies (Cull & Gill, 1982; Faigel, 1966; Freese, 1979; Stein & Davis, 1982; Stillion, McDowell, & Shamblin, 1984) have connected low self-esteem with suicide probability. Our counseling experience as well as the experience of other practitioners seems to substantiate the relationship between low self-esteem and suicide probability. Almost all such clients have issues focused on feelings of low self-worth, and almost all such adolescents have experienced self-doubt for an extended time period.

***Hopelessness/helplessness.*** Most suicidal adolescents report feeling hopeless and helpless in relation to their circumstances as well as to their ability to cope with these circumstances. The research support (Cull & Gill, 1982; Jacobs, 1971; Kovacs, Beck, & Weissman, 1975; Peck, 1983) for verification of what clinicians report is growing. Most practitioners can expect to address this issue with suicidal clients and to identify a long-term history of feeling hopeless and helpless on the part of most clients.

***Isolation.*** Many, if not most, suicidal adolescents tend to develop a small network of social support. They may find it uncomfortable to make new friends and rely on a small number of friends for support and companionship. (This may be the reason why so often those around a suicide victim state they did not notice anything unusual. The suicidal adolescent may not be in the habit of getting close enough to others for changes in behavior or outlook to be noted.) A number of authorities (Hafen, 1972; Kiev, 1977; Peck, 1983; Sommes, 1984; Stein & Davis, 1982) seem to support this observation.

***High stress.*** High stress coupled with poor stress management skills seem to be characteristic of the suicidal adolescent. Several studies have addressed this trait in terms of low frustration tolerance (Cantor, 1976; Kiev, 1977).

***Need to act out.*** Behaviors such as truancy, running away, refusal to cooperate at home or at school, use or abuse of alcohol or other drugs, and experimentation with sex are frequently part of the pattern present in the life of a suicidal adolescent. Such behaviors may be manifestations of depression. Adults often remain so focused on the troublesome behavior connected with an adolescent's need to act out that underlying depressive episodes may be overlooked.

***Need to achieve.*** Sometimes adolescents who are suicidal exhibit a pattern of high achievement. This achievement may be focused on getting high grades, being the class clown, accepting the most dares, or wearing the best clothes. In our counseling experience, this emphasis on achievement often is a compensation for feelings of low self-esteem. However, jumping to the conclusion that every adolescent who achieves at a high level is suicidal is unwarranted. This trait, along with all other traits and characteristics connected with the profile of the suicidal adolescent, must be assessed in the context of other observations.

***Poor communication skills.*** Suicidal adolescents often have a history of experiencing difficulty with expression of thoughts and feelings. Such adolescents may have trouble with identifying and labeling what they are feeling; self-expression seems awkward if not stressful. It is not unusual to discover that adolescents who have become preoccupied with suicidal thoughts have experienced a series of losses or disappointments that they have never been able to discuss and, understandably, integrate or resolve.

***Other directedness.*** Most suicidal adolescents are *other* rather than *inner* directed. They are what others have told them they are instead of what they want to be; they value what others have said they should instead of what they deem to be of personal value and worth. This trait may also be linked to low self-esteem and may lead to feelings of helplessness or inability to control interactions or circumstances around them.

***Guilt.*** Usually connected with feelings of low self-esteem and a needing to be other directed, the guilt experienced by many suicidal adolescents is bothersome and sometimes linked to a wanting-to-be-punished motivation for suicide. "Nothing I do seems to be good enough," "I feel so bad because I disappointed them," or "I should not have made that decision and should have known better" are statements common to the guilt-ridden suicidal adolescent.

***Depression.*** Depression is a major element in the total profile of the suicidal adolescent. Hafen and Frandsen (1986) pointed out that there are sometimes differences between depression in an adult and depression in an adolescent. Adults are often despondent, tearful, sad, or incapable of functioning as usual. Although adolescents sometimes exhibit these characteristics, they may also respond with anger, rebelliousness, truancy, running away, and using and abusing drugs. Those adults and peers who associate depression only with feelings of sadness and despondency may not recognize depression in adolescents who mask the depression with behavior that creates discomfort in family and school environments.

> Given the complexity of being an adolescent in the late 1980s, coupled with the normal ups and downs of the developmental stage of adolescence, it is normal for every adolescent to experience short periods of depression. But when depressive periods become more and more frequent, longer and longer, and of such intensity that the adolescent has difficulty functioning at school and at home, they could be a strong warning sign of suicide potential, especially if other aspects of behavior, verbalization, motivations, and cognitive distortions have been observed. (Capuzzi, 1988, p. 10)

It is extremely important for counselors and other kinds of professionals who may be working with suicidal adolescents to complete additional coursework or training experiences to learn about the different types of depression. Although familiarity with resources and guidelines such as those provided by McWhirter and Kigin (1988) and the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) (American Psychiatric Association, 1994) are readily available to mental health practitioners, case supervision and consultation may be needed to determine accurately the nature of a depressive episode. Well-meaning practitioners frequently fail to discriminate between depression created by a constellation of factors (negative self-talk, poor problem-solving skills, high stress) and depression that is endogenous and a result of the body chemistry an adolescent inherited at birth. Treatment or counseling plans are different based on the kind of depression being experienced. Counselors, therapists, and core or crisis team members need to consult with nurse practitioners and psychiatrists when medical assessment and subsequent medication are appropriate for endogenous depression.

***Poor problem-solving skills.*** Most parents notice differences in the problem-solving abilities of their children. Some children are more resourceful than others in identification of problem resolution options. Suicidal adolescents seem, in our experience, to have less ability to develop solutions to troublesome situations or uncomfortable relationships. This may be a reason why suicidal preoccupation can progress from a cognitive focus to an applied plan with little dissonance created by the formulation and consideration of other problem-solving options and decision.

## CASE STUDY: THE STORY OF JIM

Jim was a 17-year-old high school junior and the son of affluent, well-educated parents. Jim's dad was a successful attorney, and his mom was an assistant superintendent for the local school district. Jim's sister, Janell, was 15, well liked, a cheerleader, and involved in a variety of school and community-related activities. Janell had a beautiful singing voice and frequently accepted prominent roles in school, church, and community musical productions.

Although Jim had a few close friends, he preferred to spend most of his time reading and studying and was a straight "A" student. He accepted an opportunity to spend most of his junior year traveling and studying in Europe and thought such an experience would provide an excellent educational option as well as time away from his parents. Jim resented the high expectations his parents placed on both him and Janell and felt that his father did not approve of an earlier decision not to participate in varsity sports. Both parents, Jim felt, pressured him to be involved in school and community civic and social organizations; Jim preferred more solitary and intellectual pursuits. Jim felt somewhat self-conscious and awkward in social situations and never felt that he could present himself as well as his sister or in a way acceptable to his parents. He felt directed and criticized by both parents and resented the fact that his parents always seemed too busy to listen to him talk about things of importance to him. He really resented his father's lack of approval and felt that no one in his family seemed really to understand his point of view.

Jim had experienced periodic episodes of depression, and because he had decided that it was best not to talk with family members about his feelings, he usually tried to keep his sister and his parents from knowing that he felt really down. Jim noticed that his depression was the worst when he was under a lot of stress with respect to completing class assignments and during times that his parents pressured him into social situations. Bob, Jim's best friend, got so concerned about Jim toward the end of the exam period in the spring of their sophomore year that he told Jim's parents. Jim's parents took him to a psychiatrist who prescribed an antidepressant and recommended weekly therapy. Jim's parents were angry with their son, resented the additional expense, and demanded that Jim get better as soon as possible. Janell hoped her friends would not find out because she was in the midst of being nominated for Queen of the Rose Festival and had already been selected as a Rose Festival Princess. Jim did not like the psychiatrist and felt as criticized by him as he did by his parents. He disliked the side effects of the medication, often skipped his weekly therapy session, and could hardly wait to leave home in late August to attend the orientation session at Cambridge prior to initiation of his travel/study itinerary.

Shortly after Thanksgiving Jim's parents received a call from Switzerland. Jim had nearly died after an overdose of his medication and was recovering in a hospital in Zurich. Jim was sent home during the first part of December.

## APPROACHES TO PREVENTION

### Family

Most suicidal adolescents have developed their at-risk profiles over time beginning during early childhood. In families in which there is more than one child, it is often easy for parents to identify differences in self-esteem, communication skills, stress management, and problem solving. By the time a child is in elementary school, there may be visible indicators or traits that, if no intervention takes place, will result in the child's involvement in one or several at-risk behaviors. Such a child, by the time the middle school or junior high transition occurs, will be vulnerable to becoming pregnant, contracting AIDS, abusing drugs, developing an eating disorder, dropping out of school, or attempting or completing suicide.

Jim's family could have noted Jim's low self-esteem, discomfort with respect to sharing feelings, depression, response to stress, poor stress-management skills, and resentment toward them. They might have been able to detect changes in his thinking patterns or fluctuations in day-to-day behaviors had they developed a relationship with him that included more open lines of communication. Jim's parents did not realize that their son experienced even higher levels of stress in conjunction with the European study program and felt compelled to succeed at all costs. Jim also did not anticipate the amount of interchange and collaboration required by the group living situations he found himself in as he and his peers and teachers traveled from one community to another, and he had begun to feel less self-assured than ever. Ideally, Jim's parents should have sought counseling assistance for themselves and their son when Jim was in elementary school.

## Individual

Individually focused preventive counseling with Jim could have been focused in several ways. Jim could have benefited from a therapeutic relationship that included self-esteem enhancement as part of the treatment plan. If counseling/therapy had been initiated during elementary school years, Jim might not have responded with depression and, to a great extent, isolation and withdrawal from all but a few friends who provided a limited network of social support. Jim might also have been encouraged to share feelings and communicate with his parents. He also could have benefited from assertiveness training to assist him with sending needed messages to his parents at times when his parents were more preoccupied with career-related responsibilities and interests. Jim's counselor/therapist could have worked with him to become more aware of stressors and more adept at managing stress and/or removing stressors from his environment. Possibly, the combination of efforts made by his parents in couples counseling and by Jim in the context of his individual work could have resulted in outcomes very different than those described in his case study.

## School and Community

There are a number of steps that can be taken to involve both the school and the community in prevention efforts. In general, initiating efforts in the school setting is easier than in the context of a mental health center because, for example, schools can easily access young people, reach and prepare school faculty and staff, involve parents, and collaborate with mental health professionals from the surrounding community.

Steps for facilitating a successful school-community prevention effort include negotiation with administrators, faculty/staff inservice, preparation of crisis teams, providing for individual and group counseling options, parent education, and classroom presentations.

***Negotiation with administrators.*** The need to put prevention, crisis management, and postvention programs for the adolescent suicide problem in place in elementary, middle, and high schools throughout the country is compelling. However, one of the biggest mistakes made by counselors, educators, and coordinators of counseling/student services is to initiate programs and services in this area without first obtaining commitment and support of administrators and others in supervisory positions. Too often efforts are initiated and then canceled because little or no negotiation with those in decision-making positions has taken place. Building principals must be supportive; otherwise all efforts are destined for failure. Developing understanding of the parameters connected with suicide prevention and intervention must start with the building principal and extend to all faculty and staff in a given building so that advance understanding of why quick action must take place is developed. During a crisis, schedules must be rearranged, and faculty and staff may be called upon to teach an extra class or assist with an initial assessment. Everyone connected with a given building must have advance preparation.

In addition to the groundwork that must be done on the building level, also important is to effect advance communication and planning on the district level. The superintendent, assistant superintendent, curriculum director, staff development director, student services coordinator, and research and program evaluation specialist must all commit their support to intervention efforts. When administrators have the opportunity to listen to an overview of proposed efforts and ask questions, a higher level of commitment can be established and efforts can be more easily expedited. The probability of extending proposed programming to all schools in a given district is also increased.

***Faculty/staff inservice.*** Because teachers and other faculty and staff usually learn of a student's suicidal preoccupation prior to the situation being brought to the attention of the school counselor or another member of the core or crisis team (assuming such a team exists), *all* faculty and staff must be included in building- and/or district-level inservice on the topic of adolescent suicide. Teachers, aides, secretaries, administrators, custodians, bus drivers, food service personnel, librarians, and school social workers come in contact with adolescents at risk for suicide. It is imperative that all such adults be educated about both adolescent suicide and building and district policies and programs for prevention, crisis management, and postvention. When a young person reaches out to a trusted adult, that adult must have a clear understanding and a considerable amount of self-confidence so he or she knows exactly what to say and do as well as what not to say and do.

Many schools and school districts have actually precipitated suicide attempts by not providing for faculty/staff inservice on the topic prior to introducing discussion among student groups. When middle and high school students participate in educational programs on the topic of adolescent suicide, they begin to realize that they, as well as some of their friends, are at risk, and they approach admired adults for assistance. Adults in the school who have no knowledge of what to do and who have not had the opportunity to have their questions answered and their apprehension lowered may be threatened by what a student is sharing and fail to make appropriate comments and decisions. Highly stressed, depressed, suicidal adolescents do not have the perspective to realize that such responses are connected with discomfort on the part of the adult and have little to do with what could be interpreted as disapproval and lack of acceptance. Awkward and minimal responses to suicidal self-disclosure on the part of a trusted adult can be interpreted as the loss of the last link to society and provide additional reinforcement for finalizing a suicide plan.

**It is unethical not to prepare school faculty and staff in advance of the presentation of information on suicide to the students in a school. To do so could also become the basis for legal action by parents and family members.** Much of the content in this chapter can become the basis for necessary inservice efforts.

***Preparation of crisis teams.*** Many schools have crisis or core teams composed of faculty, staff, and parents connected with a particular building. These teams often exist in conjunction with a program for the prevention and intervention efforts necessary to cope with the drug problem among the young people in today's schools. Such teams usually consist of some combination of teachers, counselors, parents, social workers, school psychologists, school nurses, and school administrators. Usually these teams have been educated about traits that place adolescents at risk for substance use and abuse and have had supervision and instruction on the use of appropriate communication, diagnostic, and intervention skills necessary to begin the long-term process of recovery from alcoholism and other addictions.

With education beyond that provided during the faculty/staff inservice, and with additional supervision and evaluation of clinical skills, a core or crisis team can be taught how to facilitate prevention efforts in a school and how to respond to a student already experiencing a suicidal crisis or in need of postvention efforts. In addition, a core or crisis team can be expected to write a policy statement that covers all parameters connected with prevention, crisis management, and postvention efforts. Such a policy could be adopted in other schools;

in reality, except for specifics connected with a given building, the same policy statement should be adopted and followed throughout a school district. It is important to realize that everyone who is called upon to assist a suicidal adolescent must know what to do. Confusion or lack of certainty about a chain of command or procedure for notification of parents can result in delays and interfere with efforts to save a young person's life!

***Individual and group counseling options.*** Prior to providing students with any information about suicide and suicide prevention efforts in a school, arrangements must be made for the individual and group counseling services that will be needed by those who seek assistance for themselves or their friends. Unless such counseling options are available, any effort at prevention, crisis management, or postvention is doomed to failure. This may present a problem to school personnel, particularly on the secondary level, unless there is a commitment on the part of administrators to free counselors from scheduling, hall monitoring, and other duties not related to the emerging role of the counselor of the 1980s and 1990s. Working with suicidal adolescents requires a long-term commitment on the part of those interested in intervening. No counselor, psychologist, or social worker can undo the life experiences and self-perceptions of a lifetime without providing consistent, intensive opportunities for counseling.

If the school district cannot make a commitment to providing counseling, then arrangements for referral to community agencies and private practitioners must be made. It is important to provide adolescents and their families with a variety of referral possibilities along with information on fee schedules. There may be some question about whether the school district is liable for the cost of such counseling if the referral is made by the school. (This issue should be explored by whatever legal counsel is retained by the district.) The dilemma, of course, is that unless counseling takes place when a suicidal adolescent has been identified, the probability is high that an attempt or a completion will take place. If the school is aware of a teenager's suicidal preoccupation and does not act in the best interests of such a teenager, families may later bring suit against the district.

***Parent education.*** Parents of students in a school in which a suicide prevention program is to be initiated should be involved in the school's efforts to educate, identify, and assist young people in this respect. Parents have a right to understand why the school is taking such steps and what the components of a schoolwide effort will be like. Evening or late afternoon parent education efforts can be constructive and engender additional support for a school or school district. Parents have the same information needs as faculty and staff with respect to the topic of adolescent suicide. They will be more likely to refer themselves and their children to the school for assistance if they know of the school's interest in adolescent suicide prevention, have had an opportunity to ask questions about their adolescent son's and daughter's behavior, and have been reassured about the quality and safety of the school's efforts.

***Classroom presentations.*** Debate surrounding the safety of adolescent suicide prevention programs containing an educational component that is presented to adolescents continues. This debate is similar to the one that emerged years ago when schools initiated staff development and classroom presentations on the topic of physical and sexual abuse. Advocates of education and discussion efforts focused on students in conjunction with a schoolwide suicide prevention effort include Capuzzi (1988, 1994), Capuzzi and Golden (1988), Curran (1987), Ross (1980), and Sudak, Ford, and Rushforth (1984).

Providing adolescents with an appropriate forum in which they can receive accurate information, ask questions, and learn about how to obtain help for themselves and their friends does not precipitate suicidal preoccupation or attempts (Capuzzi, 1988, 1994). Because newspaper and television reports of individual and cluster suicides do not usually include adequate education on the topic, and because many films have unrealistically presented or romanticized the act of suicide, it is important for schools to address the problem in a way that provides information and encourages young people to reach out for help prior to reaching the point of despair.

A carefully prepared and well-made classroom presentation by a member of the school's core team (or another presenter who has expertise on the topic) is essential. Such a presentation should include information on causes, myths, and symptoms as well as information on how to obtain help through the school. **Under no circumstances should media be used in which adolescents are shown a suicide plan**. In addition, on the elementary level, school faculty should not present programs on the topic of suicide prevention; their efforts are better focused on developmental counseling and classroom presentations directed at helping children overcome traits (such as low self-esteem or poor communication skills) that may put the children at risk for suicidal behavior at a later time. Although these efforts should be continued through secondary education, middle and high school students are better served through presentations that address adolescent suicide directly. (Middle and high school students almost always have direct or indirect experience with suicide and appreciate the opportunity to obtain information and ask questions.)

## INTERVENTION STRATEGIES

### Individual and Family

Some times adolescents at risk for suicide are not identified until a crisis state has been reached. At such times, it is important for all concerned to initiate action for the purpose of assessing lethality and determining appropriate follow-up. Because many professionals who are not counselors lack experience with adolescents in the midst of a personal crisis, the following guidelines may prove helpful. The guidelines can be read in the context of working with Jim—assuming that all the adults traveling with Jim and his peers have participated in staff development efforts and include a counselor or other professional who can assess suicidal risk.

***1. Remember the meaning of the term* crisis management.** When thinking of crisis management, it is important to understand the meaning of the word crisis as well as the word *management*. The word crisis means that the situation is not usual, normal, or average; circumstances are such that a suicidal adolescent is highly stressed and in considerable emotional discomfort. Adolescents in crisis usually feel vulnerable, hopeless, angry, low in self-esteem, and at a loss for how to cope. The word *management* means that the professional involved must be prepared to apply skills different from those required for preventive or postvention counseling. An adolescent in crisis must be assessed, directed, monitored, and guided for the purpose of preventing an act of self-destruction. Because adolescents who are experiencing a suicidal crisis may be quite volatile and impulsive, the need for decisive, rapid decision making on the part of the intervener is extremely important.

***2. Be calm and supportive.*** A calm, supportive manner on the part of the intervener conveys respect for the perceptions and internal pain of an adolescent preoccupied with suicidal thoughts. Remember that such an adolescent usually feels hopeless and highly stressed. The demeanor and attitude of the helping person are pivotal in the process of offering assistance.

***3. Be nonjudgmental.*** Statements such as "you can't be thinking of suicide, it is against the teachings of your church" or "I had a similar problem when I was your age and I didn't consider suicide" are totally inappropriate during a crisis situation. An adolescent's perception of a situation is, at least temporarily, reality, and that reality must be respected. The same caution can be applied to the necessity of respecting a suicidal adolescent's expression of feelings—whether depression, frustration, fear, or helplessness. Judgmental, unaccepting responses and comments only serve to further damage an already impaired sense of self-esteem and decrease willingness to communicate. Adolescents could sink further into depression or increase their resolve to carry through with a suicide plan if others are critical and unwilling to acknowledge what appear, to the adolescent, to be unsurmountable obstacles.

***4. Encourage self-disclosure.*** The very act of talking about painful emotions and difficult circumstances is the first step in what can become a long-term healing process. A professional helper may be the first person with whom such a suicidal adolescent has shared and trusted in months or even years, and it may be difficult to do simply because of lack of experience with communicating thoughts and feelings. Supporting and encouraging self-disclosure so that an assessment of lethality can be made early in the intervention process is important.

***5. Acknowledge the reality of suicide as a choice—but do not normalize suicide as a choice.*** Practitioners should let adolescents know that they are not alone and isolated with respect to suicidal preoccupation. Practitioners should also communicate the idea that suicide is a choice, a problem-solving option, but that there are other choices and options. This may be difficult to do in a way that does not make the adolescent feel judged or put down. An example of how to convey the essential ideas to an adolescent in crisis is to say "It is not unusual for adolescents to be so upset with relationships or circumstances that thoughts of suicide occur more and more frequently; this does not mean that you are weird or a freak. I am really glad you have chosen to talk to me about how you're feeling and what you are thinking. You have made a good choice since now you can begin exploring other ways to solve the problems you described."

***6. Actively listen and positively reinforce.*** During the initial stages of the crisis management process, let the adolescent at risk for suicide know you are listening carefully and really understanding how difficult life has been. Not only does such careful listening and communicating, on the part of the professional, make it easier for the adolescent to share, but it also provides the basis for a growing sense of self-respect. Being listened to, heard, and respected are powerful and empowering experiences for anyone who is feeling at a loss for how to cope.

***7. Do not attempt in-depth counseling.*** Although a suicidal adolescent needs to begin to overcome feelings of despair and to develop a sense of control as soon as possible, the emotional turmoil and stress experienced during a crisis usually makes in-depth counseling impossible. Of most importance is developing a plan to begin lessening the sense of crisis an adolescent may be experiencing. This crisis management plan should be accomplished as soon as possible and should be shared with the adolescent so that it becomes clear that circumstances will improve. Counseling/therapy cannot really take place during the height of a suicidal crisis.

***8. Contact another professional.*** Enlist the assistance of another professional with training in crisis management when an adolescent thought to be at risk for suicide is brought to your attention. School and mental health counselors should ask a colleague to come into the office and assist with assessment. Having the support of a colleague who understands the dynamics of a suicidal crisis is always a good idea. In addition, the observations made by two professionals are more likely to be more comprehensive. Because suicidal adolescents may present a situation that if misjudged or mismanaged could result in a subsequent attempt or completion, it is in the best interests of both the professional and the client for professionals to work collaboratively whenever possible. Note that liability questions are less likely to become issues and professional judgment less likely to be questioned if assessment of the severity of a suicidal crisis and associated recommendations for crisis management have been made on a collaborative basis.

***9. Ask questions to assess lethality.*** The assessment of lethality can be accomplished through an interview format (a crisis situation is not conducive to the administration of a written appraisal instrument). The following questions help determine the degree of risk in a suicidal crisis. All may not need to be asked if information is spontaneously disclosed in the interview.

- "*What has happened to make life so difficult?*" The more an adolescent describes the circumstances that have contributed to feelings of despair and hopelessness, the better the opportunity for effective crisis management. The process of describing stress-producing interpersonal situations and circumstances may begin to lower feelings of stress and reduce risk. It is not unusual for an adolescent in the midst of a suicidal crisis to describe a multifaceted set of problems with family, peers, school, and drugs. The more problems an adolescent describes as stress-producing and the more complicated the scenario, the higher the lethality or risk.
- "*Are you thinking of suicide?*" Adolescents who have been preoccupied with suicidal thoughts may experience a sense of relief to know there is someone who is able to discuss suicide in a straightforward manner. Using the word *suicide* will convey that the helping professional is listening and is willing to be involved; using the word *suicide* will not put the idea of suicide in the mind of a nonsuicidal adolescent.
- "*How long have you been thinking about suicide?*" Adolescents who have been preoccupied with suicide for a period of several weeks are more lethal than those who have only fleeting thoughts. One way to explore several components of this question is to remember the acronym FID. When asking about suicidal thoughts, ask about *frequency* or how often they occur, *intensity* or how dysfunctional the preoccupation is making the adolescent ("Can you go on with your daily routine as usual?"), and *duration* or how long the periods of preoccupation last. Obviously, an adolescent who reports frequent periods of preoccupation so intense that it is difficult or impossible to go to school, to work, or to see friends, and for increasingly

longer periods of time so that periods of preoccupation and dysfunction are merging, is more lethal than an adolescent who describes a different set of circumstances.

- *"Do you have a suicide plan?"* When an adolescent is able to be specific about the method, the time, the place, and who will or will not be nearby, the risk is higher. (If the use of a gun, knife, medication, or other means is described, ask if that item is in a pocket or purse and request that the item be left with you. Never, however, enter into a struggle with an adolescent to remove a firearm. Call the police or local suicide or crisis center.) Most adolescents will cooperate with you by telling you about the plan and allowing you to separate them from the means. Remember, most suicidal adolescents are other-directed; such a trait should be taken advantage of during a crisis management situation. Later, when the crisis has subsided and counseling is initiated, the adolescent's internal locus of control can be strengthened.
- *"Do you know someone who has committed suicide?"* If the answer is "yes," the adolescent may be of higher risk, especially if this incident occurred within the family or a close network of friends. Such an adolescent may have come to believe that suicide is a legitimate problem-solving option.
- *"How much do you want to live?"* An adolescent who can provide only a few reasons for wishing to continue with life is of higher risk than an adolescent who can enumerate a number of reasons for continuing to live.
- *"How much do you want to die?"* The response to this question provides the opposite view of the one above. An adolescent who gives a variety of reasons for wishing to die is more lethal than an adolescent who cannot provide justification for ending life. It may be unnecessary to ask this question if the previous question provided adequate data.
- *"What do you think death is like?"* This question can be an excellent tool for assessment purposes. Adolescents who do not seem to realize that death is permanent, that there is no reversal possible, and that they cannot physically return are at higher risk for an actual attempt. In addition, adolescents who have the idea that death is romantic, nurturing, or the solution to current problems are at high risk.
- *"Have you attempted suicide in the past?"* If the answer to this question is "yes," then the adolescent is more lethal. Another attempt may occur that could be successful because a previous attempter has the memory of prior efforts and has already conceptualized and carried through with a suicide plan. An additional attempt may correct deficits in the original plan and result in death.
- *"How long ago was this previous attempt?"* This question should be asked of any adolescent who answers "yes" to the preceding question. The more

recent the previous attempt, the more lethal the adolescent and the more critical the crisis management process.

- *"Have you been feeling depressed?"* Because a high percentage of adolescents who attempt or complete suicide are depressed, this is an important question. Using the acronym FID to remember to ask about frequency, intensity, and duration is also helpful in the context of exploring an adolescent's response to this question. As previously discussed, a determination needs to be made relative to the existence of clinical depression if such a condition is suspected. Adolescents who report frequent, intense, and lengthy periods of depression resulting in dysfunctional episodes that are becoming closer and closer together, or are continuously experienced, are at high risk.
- *"Is there anyone to stop you?"* This is an extremely important question. If an adolescent has a difficult time identifying a friend, family member, or significant adult who is worth living for, the probability of a suicide attempt is high. Whoever the adolescent can identify should be specifically named; addresses, phone numbers, and the relationship to the adolescent should also be obtained. (If the adolescent cannot remember phone numbers and addresses, look up the information, together, in a phone book.) In the event it is decided that a suicide watch should be initiated, the people in the network of the adolescent can be contacted and asked to participate.
- *"On a scale of 1 to 10, with 1 being low and 10 being high, what is the number that depicts the probability that you will attempt suicide?"* The higher the number, the higher the lethality.
- *"Do you use alcohol or other drugs?"* If the answer to this question is "yes," the lethality is higher because use of a substance further distorts cognition and weakens impulse control. An affirmative response should also be followed by an exploration of the degree of drug involvement and identification of specific drugs.
- *"Have you experienced significant losses during the past year or earlier losses you've never discussed?"* Adolescents who have lost friends because of moving, vitality because of illness, or their family of origin because of a divorce are vulnerable to stress and confusion and are usually at higher risk for attempting or completing suicide if they have been preoccupied with such thoughts.
- *"Have you been concerned, in any way, with your sexuality?"* This may be a difficult question to explore, even briefly, during a peaking suicidal crisis. Generally, adolescents who are, or think they may be, gay or lesbian are at higher risk for suicide. It is quite difficult for adolescents to deal with the issue of sexual orientation because of fear about being ridiculed or rejected. They may have experienced related guilt and stress for a number of years, never daring to discuss their feelings with anyone.

- *"When you think about yourself and the future, what do you visualize?"* A high-risk adolescent will probably have difficulty visualizing a future scenario and will describe feeling too hopeless and depressed to even imagine a future life.

As noted at the beginning of this discussion, it is not necessary to ask all of these questions if the answers to them are shared during the course of the discussion. It should also be noted that the interviewing team must make judgements about the truthfulness of a specific response by considering the response in the total context of the interview.

***10. Make crisis management decisions.*** If, as a result of an assessment made by at least two professionals, the adolescent is at risk for suicide, a number of crisis management interventions can be considered. They may be used singly or in combination; the actual combination depends upon the lethality determination, resources and people available, and professional judgment. It is the responsibility of the professionals involved, however, to develop a crisis management plan to be followed until the crisis subsides and long-term counseling or therapy can be initiated.

*Notifying parents.* Parents of minors must be notified and asked for assistance when an adolescent is determined to be at risk for a suicide attempt. Often, adolescents may attempt to elicit a promise of confidentiality from a school or mental health counselor who learns about suicidal intent. Such confidentiality is not possible; the welfare of the adolescent is the most important consideration, and parents should be contacted as soon as possible.

Sometimes parents do not believe that their child is suicidal and refuse to leave home or work and meet with their son or daughter and members of the assessment team. At times parents may be adamant in their demands that the school or mental health professional withdraw their involvement. Although such attitudes are not conducive to the management of a suicidal crisis, they are understandable because parents may respond to such information with denial or anger to mask true emotions and cope with apprehensions that perhaps their child's situation reflects their personal inadequacies as people and parents. Because an adolescent at risk for a suicide attempt cannot be left unmonitored, this provides a dilemma for a school or a mental health agency. When conforming to the wishes of noncooperative parents places the adolescent at even greater risk, steps must be taken despite parental protests. Although some professionals worry about liability issues in such circumstances, liability is higher if such an adolescent is allowed to leave unmonitored and with no provision for follow-up assistance. Schools and mental health centers should confer with legal counsel to understand liability issues and to make sure that the best practices are followed in such circumstances.

*Considering hospitalization.* Hospitalization can be the option of choice during a suicidal crisis (even if the parents are cooperating) when the risk is high. An adolescent who has not been sleeping or eating, for example, may be totally exhausted or highly agitated. The care and safety that can be offered in a psychiatric unit of a hospital is often needed until the adolescent can experience a lowered level of stress, obtain food and rest, and realize that others consider the circumstances painful and worthy of attention. In many hospital settings, multidisciplinary teams (physicians, psychiatrists, counselors, social workers, nurses, nurse practitioners, teachers) work to individualize a treatment plan and provide for outpatient help as soon as the need for assistance on an inpatient basis subsides.

*Writing contracts.* At times, professionals may decide that developing a contract with the adolescent may be enough to support the adolescent through a period of crisis and into a more positive frame of mind after which the adolescent will be more receptive to long-term counseling or therapy. Such a contract should be written out and signed and dated by the adolescent and the counselor. The contract can also be witnessed and signed by other professionals, friends, or family members.

Contracts should require the adolescent to

1. agree not to attempt suicide;
2. obtain enough food and sleep;
3. discard items that could be used in a suicide attempt (guns, weapons, medications);
4. specify the time span of the contract;
5. call a counselor or crisis center if there is a temptation to break the contract or attempt suicide;
6. write down the phone numbers of people to contact if the feeling of crisis escalates; and
7. specify ways time will be structured (walks, talks, movies).

*Organizing suicide watches.* If hospital psychiatric services on an inpatient basis are not available in a given community and those doing the assessment believe the suicide risk is high, a suicide watch should be organized by contacting the individuals that the adolescent has identified in response to the question, "Is there anyone to stop you?" After receiving instruction and orientation from the professional, family members and friends should take turns staying with the adolescent until the crisis has subsided and long-term counseling or therapy has begun. In our opinion, it is never a good idea to depend on a family member alone to carry out a suicide watch; it is usually too difficult for family members to retain perspective. Friends should be contacted and included in a suicide watch even though confidentiality, as discussed earlier, cannot be maintained.

## School and Community

When an adolescent has attempted or completed a suicide, it is imperative, particularly in a school setting, to be aware of the impact of such an event on the system. Usually, within just a few hours, the fact that an adolescent has attempted or completed suicide has been chronicled through the peer group. This could present a problem to the faculty and staff in a given school building because not answering questions raised by students can engender the sharing of misinformation or rumors, and encouraging open discussion could embarrass an attempter upon his or her return.

The following guidelines should prove helpful. Had Jim been in the regular school program when he made his attempt, these guidelines would have been put into effect immediately:

1. The principal of the building in which a student has attempted or completed suicide (even though such an incident most likely occurred off the school campus) should organize a telephone network to notify all faculty and staff that a mandatory meeting will take place prior to school the next morning. The principal should share information and answer questions about what happened during such a meeting.
2. Faculty and staff should be instructed to answer student questions that spontaneously arise but should be told not to initiate a discussion of suicide in general.
3. Faculty and staff should be told to excuse students from class if they are upset and need to spend time in the office of the building counselor or another member of the core or crisis team.
4. Parents who are upset by the suicidal incident should be directed to a designated individual to have questions answered. Parents should also be provided with options for counseling, whether this counseling is provided by school personnel or referred to members of the mental health community.
5. At times, newspaper and television journalists contact the school for information about both the attempt or the completion and the school's response to the aftermath. Again, it is important to direct all such inquiries to a designated individual to avoid the problems created by inconsistency or sharing inaccurate information.
6. If a suicidal attempt occurs prior to the initiation of prevention and crisis management efforts in a given building, it is not a good idea to initiate classroom mental health education immediately even if faculty, staff, and core teams have been prepared and a written policy has been developed. Allow sufficient time to pass to prevent embarrassment to the returning student and his or her family.
7. Be alert to delayed or enhanced grief responses on the part of students prior to the anniversary of a suicide completion. Often students need

opportunities to participate in a support group with peers or individual counseling prior to and, perhaps, beyond the anniversary date.

## ADAPTATIONS FOR DIVERSITY

Information in the first section of this chapter suggests a number of adaptations for diversity, particularly with respect to prevention efforts. Because data suggest that Caucasian adolescent males are the highest risk group for suicide, extra efforts should be make to involve those young men, who may be vulnerable, in early prevention efforts. Individual and group counseling, focused on some of the personality traits described earlier, could and should be initiated in the elementary school years. Such early prevention efforts are preferable to waiting until suicidal preoccupation develops and behavior can be observed. Because Native Americans have the highest adolescent suicide rates of any ethnic group in the United States, teachers, counselors, and parents should be alerted to early signs so that efforts can be made to avert the development of at-risk behaviors.

All adults should be made aware of the etiology of suicide so that young people experiencing psychiatric illness, abuse, confusion about sexual identity, or chronic or terminal physical illness can be monitored, supported, and referred for counseling/therapy where needed. Staffing sessions should be routinely conducted in elementary, middle, and high school settings so that young people who may be at risk for suicide attempts or completions could be routinely monitored and assisted. Because we know that adolescents who experience what they interpret as shameful or humiliating experiences with peers and with family members may, at times, be at high risk, these young people should also be the focus of observation and action should the need for prevention or intervention efforts be identified. In general, the more adults can be made aware of both risk factors and the suicidal profile, the earlier and more effective the prevention or intervention efforts.

## SUMMARY

We believe that individuals who are interested in working with suicidal youth must obtain more extensive information than that provided in this chapter. In addition, such individuals should obtain supervision from qualified professionals after observing actual assessment interview and counseling/therapy sessions. Generally, neither assessment, preventive, or postvention sessions should be attempted by anyone who has graduated from a graduate program with less than a 2-year coursework and practicum/internship requirement. (In the case of counselors, such a graduate program should follow the standard set by the Council for the Accreditation of Counseling and Related Educational Programs.) In addition, membership in the American Association of Suicidology, participation in workshops and conferences focused on the topic of adolescent suicide, and consistent reading of *Suicide and Life-Threatening Behavior* and other books and journals are imperative.

In addition, the material in this chapter should not be used as the sole basis for mental health education on the topic of adolescent suicide prevention or faculty/staff development in schools. This chapter provides an overview and an excellent starting point for professionals. Those without expertise on the topic or graduate preparation as a counselor, social worker, psychologist, or psychiatric nurse will not be able to answer questions of clients, families, and other professionals on the basis of reading a single chapter on this topic. Finally, no one should initiate adolescent suicide prevention, crisis management, and postvention programs without writing a description of the various components so it can be checked by other professionals (including attorneys) and followed by all those involved in such an initiative.

An adolescent who becomes suicidal is communicating the fact that he or she is experiencing difficulty with problem solving, managing stress, and expressing feelings. It is important for us to respond in constructive, safe, informed ways because the future of our communities (whether local, national, or international) is dependent upon individuals who are positive, functional, and able to cope with the complex demands of life. As research and clinical experience provide additional and more sophisticated information about adolescent suicide, it will be necessary to incorporate this information into prevention, crisis management and postvention efforts. To abdicate our responsibility to do so would communicate a lack of interest in the youth of today and a lack of concern about the future of society.

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# 12

# Tough Enough: Gang Membership

*Carol A. Burden, Kay E. Miller, and Alcena E. Boozer*

Gang organization, presence, and activity are not new concepts. A cursory survey of the historical record and literary works testifies to the existence of groups that meet the criteria established by Jackson and McBride (1987): "A gang is a group of people that form an allegiance for a common purpose, and engage in unlawful or criminal activity" (p. 20). Spergel (1990) concurred that "the principal criterion currently used to define a 'gang' may be the group's participation in illegal activity" (p. 179).

Robin Hood and his Merry Men are perhaps the most celebrated gang in literature. Not unlike some gangs operating today, Robin Hood's gang was believed to be helpful by some people in the communities in which it operated. Often modern street gangs first present themselves as protectors of the community. Yet Robin Hood's Merry Men carried weapons, and their behavior, even though they robbed from the rich to give to the poor, was illegal under existing criminal codes of the era.

In the United States, western outlaws of the 19th century were the first gang members (Jankowski, 1991). All kinds of gangs were active in robbing stage coaches, banks, mines, and saloons; some of the more famous were the Doolin, Dalton, and James gangs. Gang activity, then as now, demanded a response from government officials. The governor of Missouri, for example, offered a reward for the arrest of the Jesse James gang.

As the 19th century moved toward its end, American society was faced with the problem of assimilating millions of immigrant workers from numerous countries into its cities. Some had harder times securing jobs, and some members of these groups saw an opportunity for socioeconomic mobility in crime and pursued those opportunities. The best known gangs were active in Chicago and New York. The same violent, illegal behaviors of robbery, assault, and murder characterized the 20th century version of the gangs. Neighborhoods were sometimes severely affected as gangs battled each other for territorial control and routinely robbed, beat, or killed people as gang members sought to instill fear in a community.

By the 1940s the gang activity in the western part of the United States was most clearly manifested in southern California Hispanic communities. Jackson and McBride (1987) described the early California gangs as encompassing street gangs, car clubs, and prison gangs. Although there were known Asian, African American, and Caucasian gangs operating in California from the 1920s, the Hispanic gangs attracted the most interest of researchers because of the similarity of their internal structure.

> The structure of Hispanic street gangs is similar throughout the Western states. Codes of conduct have been established from which traditions have evolved over generations. These traditions are not written, but are handed down orally from generation to generation and are referred to as *Moridas*. (p. 31)

One of the most frustrating characteristics of the modern youth gang that has evolved along the West Coast is the undefined nature of its structure. There seem to be no elective offices. One California gang investigator described it to a group of educators and law enforcement officers at a street gang training session meeting in Anaheim in 1987: "The leader is whoever is acting out most violently at a given time" (cited in Boozer, 1989, p. 306). There is, therefore, little real internal control over the behavior of individual members, and it is difficult to predict their behavior.

This chapter examines the youth gang phenomenon by examining why gangs form, the impact of gangs upon society, and risk factors for gang involvement. A case study profiles a young man involved in gangs as a way of understanding the reality of those factors as well as the needs that gangs meet. The focus then shifts to an understanding of diversity and gang involvement, prevention approaches, and, finally, intervention strategies.

## REASONS FOR GANG INVOLVEMENT

Researchers and theorists have both been challenged to explain reasons for the development and continued growth of gangs. An overview of some of the major theorists may help us to comprehend better the many factors that need to be considered in understanding gang activity.

In 1927, Thrasher identified youth gangs as the socialization agents for the graduation of young delinquents to organized crime. Gangs were viewed as a natural progression from, and the consequence of, an adolescent's search for excitement in a frustrating and limiting environment. Accompanied by a general breakdown of social controls, and characterized by individuals alienated from the customary social ties, gangs formed and thrived. Most at risk were immigrants.

In 1958, Miller noted that gang members were reared in female-dominated households. During adolescence gang members became the male models for younger members as a means of learning sex-role behaviors from peers facing similar problems.

Another perspective on gangs suggests that gangs are formed as a subculture or counterculture when lower class male youth become frustrated by their lack of opportunity to attain wealth and/or status through legitimate channels (Cloward & Ohlin, 1960; Cohen, 1955). Bernard (1990) asserted that social groups have rules outlining levels of aggression in a variety of situations and that status and prestige are awarded or denied based on support of those rules.

Matza (1964) challenged the subculture theory. He postulated instead that gangs exist because adolescents are in a state of suspension between childhood and adulthood. At this age they spend most of their time with peers. As they seek to discover their male identity and to gain acceptance by a peer group, they are at risk to join gangs and conform to the gang's norms because failure to do so would threaten their status.

Another perspective on gang involvement focuses on the family. Gang members often come from "families exhibiting more family breakdown, greater poverty, poorer housing; more alcoholism, drug addiction, and major chronic illnesses; and more families involved with law enforcement and correctional agencies" (Morales, 1992). As a response to these seemingly overwhelming problems, adolescents turn to the gang as a surrogate family. This family provides belonging, recognition, and protection to its members (Morales, 1978, 1982; Morales & Sheafor, 1989, 1992; Vigil, 1988). As Morales (1992) observed, the challenge to society is that youth persist in engaging in dangerous activities in order to meet their needs for self-esteem, status, and affection.

## THE IMPACT OF GANGS ON OUR SOCIETY

These different perspectives on gangs point to the multiplicity of factors impacting the motivation for youth to participate in gang activity. Gang membership in the United States is on the increase. Existing gangs seek to increase their membership in two ways. One is to recruit younger children ages 10 to 14. In the period from 1984 to 1988, Chicago authorities reported the average age for gang membership was $13\frac{1}{2}$, down from age 15. Lucrative illegal drug trade led to the increased recruitment of children because the juvenile justice system has few available sanctions against them (Maxon & Klein, 1990). As Hoover (1994) corroborated, children as young as 8, 9, and 10 are being involved in a wide range of illicit street activities.

The other way of increasing gang membership is to expand to adjacent communities or move to totally new communities across the United States. For example, as part of their move to increase membership, members from Los Angeles gangs have moved into 49 cities located in 26 states (Maxon & Klein, 1990). Gangs are no longer a big city phenomena. According to Stover (1986), gangs can now be found in small and midsize cities across the United States. In fact, up to one third of the cities reporting gang problems had populations below 250,000.

With gangs come a host of problems for schools and communities. Most of these problems center around increased violence and crime directly or indirectly related to the sale of alcohol and drugs. For example, law enforcement statistics from East Los Angeles County show gang activity is responsible for 60% of the county's crime rate (Maxon & Klein, 1990).

Gang-related shootings are on the increase in communities where gangs reside. For example, by the end of August 1994, the number of gang-related shootings in Portland, Oregon, had already topped the total number in 1993 (Hoover, 1994). In August alone, there was a 250% increase in shooting incidents. Local authorities attributed the increase in gunfights to the need for protection and the use of younger recruits. As Jimmy Brown, who runs Oregon's Multnomah County gang resource intervention team explained it, "The more gang members use guns, the more their rivals feel a need to arm themselves too" (cited in Hoover, 1994, p. A-14). Younger members, wanting to impress older gang members, are willing to carry guns and drugs as a way of demonstrating their loyalty and commitment to the gang, often their only family.

Gangs may require public demonstrations of an individual's commitment and loyalty (Taylor, 1990). This may lead to the enactment of behaviors for which nongang members are the innocent targets and victims. In September 1988, McKinney reported there had been a 28% increase in the number of weapons found on school grounds in California. In communities where gangs are present, students bring weapons to school because they want to be prepared for gang activity, and because they are the tools of the trade.

What Thrasher (1927) observed earlier about the relationship between gangs and delinquency has been confirmed in two recent studies. Bjerregaard and Smith (1993) and Rhodes and Fischer (1993) have reported that involvement in gangs is associated with increased levels of sexual activity, delinquency, and substance abuse. Significant gender differences reported by Rhodes and Fischer are that male gang members compared with nonmembers are more likely to have been arrested. Female gang members are more likely to carry weapons than nonmember females.

Schools and their constituents are especially vulnerable. For school-age children, personal safety becomes an issue both at school and in their communities. As Cohen (1990) stated, "there is more fear of retaliation in gang-related activities than in nongang violence" (p. 14). These acts occur as drive-by shootings, intimidation by gang members, or actual beatings or shootings, all of which have occurred on school grounds.

## Risk Factors for Gang Involvement

Hochhaus and Sousa (1988), in their study of young gang members ages 13 to 16, learned from gang members that "Companionship, protection, and excitement—combined with peer pressure—are the most frequent motivations for joining a gang" (p. 75). It comes as no surprise to practitioners in the field of education that factors placing a student at risk of gang involvement differ little from those placing a student in any other at-risk category, be it dropping out of school or becoming a teen parent. Students who join gangs do not feel competent as learners, are seldom affirmed by anyone, and do not feel connected or bonded to the school.

To help identify young people most severely at risk, a publication by the National School Safety Center (NSSC) (1988) listed the following as strong indicators of probable gang involvement:

- *rumors or reliable information that a youth has not been home for several nights;*
- *evidence of increased substance abuse;*
- *abrupt changes in behavior and personality;*
- *newly acquired and unexplained "wealth"* often showered on or shared with peers (anything from sharing bags of candy with younger children to a flurry of more extravagant spending by older youth);
- *requests to borrow money;*
- *"hanging around," but being unable to discuss the problem;*
- *evidence of mental or physical child abuse;* and
- *a dress code that applies to a few:* i.e., wearing of a color, style, or item of clothing, a particular hair style, and symbols of identification. (p. 10)

Such behavior patterns are most likely to occur among youth who are from a one-parent home, with the single parent being the mother; families whose income is at or below the poverty level; children who live in a gang-infested neighborhood; or children who have parents or older siblings who are known by law enforcement agencies for their criminal activities. In addition, children who are making poor progress or achievement in school, children who are often truant or suspended from school for antisocial behavior, youth who lack hobbies or something constructive to do with their leisure time, and youth who are overly fascinated with gang-related behaviors such as drawing gang symbols or insignias, tatoos, or gang attire are likely to demonstrate the behavior patterns or warning signs associated with gang involvement.

## CASE STUDY: THE STORY OF HEZEKIAH

The case study of one young boy's experience helps us understand the children most severely at risk of becoming involved in a gang. Hezekiah (not his real name) by age 8 was referred for youth gang outreach services and was well known to the staff of the elementary school he attended. They had known him as a 2-year-old toddler who wandered the streets alone. Older children often brought him into the school where he was fed and attempts were made to contact his mother. Referrals were made to local agencies. Eventually Hezekiah was taken from his mother's custody, and a grandparent was appointed as guardian. The grandmother was also guardian for four other older boys who were abandoned by their parents. Although the grandmother expressed the desire to help her five grandsons, at age 63 she no longer had the energy, will, or resources to administer discipline consistently. There were few attempts to do anything for Hezekiah beyond the most basic needs for food and shelter. Thus he was seldom missed when he disappeared from home for hours at a time.

The people on the streets, many of them gang members, became Hezekiah's "family." From them he learned to talk and to become physically aggressive. With gang members as role models, this miniature OG (original gangster) mastered the vernacular and concomitant nonverbal behaviors. The staff at the early childhood education center he attended referred him to social workers and child development specialists for violent aggressive behavior and inappropriate sexually oriented gestures in the classroom.

The primary grades for Hezekiah were times of constant conflict with other children and the school staff. Frustrated by the seeming lack of programs to deal effectively with what was perceived as grossly inappropriate behavior, the principal resorted to out-of-school suspension. Hezekiah learned quickly that when he didn't want to be in school, he needed only to act out and the school would send him home—home to the streets where stories of his negative behavior became a source of entertainment to the members of his street family, the gang. This young man was well on his way toward becoming a neighborhood legend. His name appeared in the graffiti around the neighborhood. He organized other poorly supervised children into a minigang, whose members armed themselves with baseball bats and started to shake down the neighborhood children. At this point, the school staff contacted members of a newly formed Youth Gang Task Force, a consortium of youth-serving agencies, neighborhood activists, central program school administrators, and juvenile justice and law enforcement personnel. In the conferences and staffings scheduled, it became clear that in many ways Hezekiah was a classic example of the growth and nurturance of a gang member.

As his early life was better understood, it became apparent that Hezekiah received little attention in the home of his grandmother. He was abandoned by his mother. The people of the streets, gang members or children who looked to gang members as role models, offered the companionship he needed and sought. This extended street family also conveyed to him a sense of protection. Anybody who "messed with the little dude" had to answer to the local gang chieftain. Perhaps most important to Hezekiah, the gang was a source of excitement. It served to fill a void in his life with actions that were fun and exciting.

Hezekiah's experience so far could serve as a predictor of a life as a gang member sure to become more and more violent until, most likely before the age of 24, Hezekiah would be either incarcerated or killed. In Hezekiah's case, however, he was initially diverted from this path by the intervention of a committed alternative school faculty.

## Needs That Gangs Meet

In Hezekiah's story, three needs are discussed: companionship, protection, and excitement. These needs are often cited by gang participants as being met by their gang family. Gangs also meet the need that all individuals have to be affirmed, so that as Jesse Jackson says, they are able to say "I am somebody!"

Frequently, the first to be recruited when a gang comes to town are those who feel they are nobodies in the social milieu of their community and at school. Seng (1986) presented a conceptual framework for understanding gang development in suburban communities. The first stage Seng identified is labeled "A Company of Rejects, a loose collection of individuals each of whom is angry" (p. 10). The loose collection includes children who feel set apart for a variety of reasons and may include poor children, the ethnically different, or children considered fat, ugly, or dumb by their peers. They all share feelings of alienation from their peers or families. "It is in the high school setting that these 'rejects' find each other. They tend to hang out together, to become a loose collection of individuals" (p. 12).

Continuing to think about the needs that gangs meet for at-risk children brings us face to face with a major dilemma. How can we compete with the attraction of lots of fast, easy money, which in the eyes of children drawn to gangs is equated with economic security? Gang members as role models are powerful symbols in poorer neighborhoods. They possess the three Cs: cars, clothes, and cash. They seem to have the ability to do as they please, intimidating the normal institutions that exercise social control—the schools, churches, and, in some cases, law enforcement agencies.

Some individuals may be forced into joining gangs by their peers. Utilizing intimidation techniques, gang members undermine youth's safety and security needs. Such intimidation techniques range from extorting lunch money to physical beatings.

Gangs as surrogate families fulfill needs for security, affirmation, protection, companionship, and excitement. Most of these cited needs relate to the core issue of self-esteem. If we view the needs of the poor, the ethnically different, and the less able—all those who compose the company of rejects—from their perspective, then gang membership may be seen as a viable alternative for these youth and adaptive rather than maladaptive. The challenge is, how can we create an alternative that is at least equally attractive?

## DIVERSITY AND GANGS

Gang membership is multiracial and includes Whites, African Americans, Hispanics, and Asians. National estimates are that about three fourths of gang members are ethnic minorities. Numerically, the majority of gangs are either African American or Hispanic, with approximately 50% African American and 17 to 33% Hispanic (Goldstein, 1991). The youth gangs emerging in cities along the West Coast of the United States usually reflect the ethnic patterns of their communities. For example, there were 568 known gangs recorded in the 1987 California Gang Investigators' report. Ethnic distribution for the 568 gangs indicated that Hispanics, at 303, and African American, at 202, were the groups most heavily represented (Boozer, 1989). Asian gang activity primarily encompassed the Southeast Asian refugee community and represented a small but rapidly increasing percentage of the total number of gangs. As observed by Pottier (1982), White gangs, at 13%, reflected a small percentage of the total. The remaining number included Samoans, Filipinos, and Tongans.

A comparison of Los Angeles, California, and the Pacific Northwest illustrates how the local ethnic population is reflected in gang activity. In Los Angeles, where Hispanics represent the largest minority group, Hispanic groups are in the majority. Conversely, in the larger cities of the Pacific Northwest such as Portland, Oregon, and Seattle, Washington, where the Hispanic communities are relatively small and African Americans make up the largest ethnic minority population, African American gangs receive the most attention from investigators and social science researchers. Likewise, in communities where the Southeast Asian refugee community has rapidly increased and is concentrated, Asian gangs are perceived as a major problem.

If we accept the premises that young people join gangs to meet needs normally fulfilled through traditional institutions such as the home, church, and school, and that as a result of unequal access to economic opportunities and educational institutions, ethnic minorities have few opportunities to experience success, the overrepresentation of Hispanic and African American youth in gang activity is not an unexpected phenomenon. In assessing the ethnic distribution of youth gang activity in a community, professionals need to develop an awareness of economic and social factors that must be addressed in order effectively to discourage youth from joining gangs. Although unequal economic opportunity may in part account for the overrepresentation of ethnic minorities in youth gangs, it is important to recognize that gang activity is **not** limited to low-income youth. White gangs often include members from all economic levels (School Safety and Security Management [SSSM], 1988).

It has been the experience of cities recently encountering major youth gang problems that any organized response must be undertaken by groups and individuals who possess a thorough knowledge of the cultural experience of those who compose a given gang's membership. What follows is a brief overview of different gang types. Included in each subsection is a discussion of graffiti because it serves as a major vehicle for distinctive communication within and between gangs.

## A Profile of Asian Gangs

The Asian culture places great emphasis on family and education. Because of their experiences in their homelands, most Asians do not trust the police or governmental agencies (Palmer, 1992).

Most Asian gang members arrived in the United States as refugees who immigrated under the Home Come Act (cited in Palmer, 1992). Many who came to the United States under this act were minors or young adults who immigrated without a family unit or education. Without their families, hence their support system, they were often at loose ends and socially and financially disadvantaged. In order to survive better, these unaccompanied minors often misrepresented their ages, with a discrepancy of 2 to 3 years so they could attend high school. In intact families, there were conflicts because the family saw its children becoming Americanized and perceived it was losing influence and control (Palmer, 1992).

Language and cultural barriers often keep Asian youth from being assimilated into the mainstream culture. As a result of this alienation, they are at risk to hang around with known gang members. Because they are often seeking immediate gratification through money, they are vulnerable to gang membership where opportunities to earn money are readily available.

Asian gangs prey primarily upon their own community through extortion, physical assaults, residential robberies, and burglary. Most members are involved for the money, and armed robbery is common. Typical targets are convenience stores and jewelry or grocery stores. Car stereos and automobiles are also favorite targets for theft. In Portland, Oregon, law enforcement agencies often see Asian gang members involved with major narcotic trafficking and weapons. Asian gangs are also very mobile. For instance, Asian gangs travel the I-5 pipeline from California to Oregon to Washington.

Asian gangs have three levels of affiliation. A *casual gang* is a group of friends who operate together in doing crime by consensus with no leadership. These members participate in the most violent of crimes. The *informal gang* is headed by a charismatic leader, but the membership fluctuates and is transient in nature. The *formal gang* has a more defined leadership with a definite chain of command. The membership is loyal, and the gang members are involved primarily in extortion (Palmer, 1992).

Asian graffiti resemble Hispanic more closely than African American in terms of stylization and attention to detail. Most frequently used to claim a territory, the graffiti contain little information other than the gang name. Once law enforcement agencies began tracing Asian graffiti in the Northwest, there was a decreased level of activity (Palmer, 1992).

## White Supremacist or Skinhead Groups

White supremacists are usually referred to as skinheads because of their closely cropped hair styles. The skinhead movement began in England in 1968 and eventually moved formally into the United States in 1984 with the formation of the Skinheads of America and Romantic Violence. In 1986, the Aryan Nation movement reached out to the skinheads to form an alliance. Skinheads are now the front-line soldiers for the white supremacist and Aryan Nation movements (Palmer, 1992).

Skinheads believe the White race is superior and that the mixing of races is taboo. They promote racial hate and violence through the distribution of hate literature targeting African Americans and other people of color. Other targets include gays, lesbians, and Jews. They intimidate and harass individuals through physical attacks and taunting with racial slurs. Weapons that might be utilized by skinheads include clubs, bats, guns, knives, and chains. The type of music they listen to is called **OI** and is sometimes used as the greeting from one skinhead to another (Palmer, 1992).

Individuals attracted to white supremacist or skinhead groups are often the nobodies or individuals who feel set apart from their environment—individuals who may be seen as loners. Especially at risk are males or females who are experiencing academic problems, who are known drug or alcohol abusers, and who have been physically or sexually abused. In the Pacific Northwest, the targeted audience for recruitment of members is blue collar, White male youth who blame others for their troubles. Many are from low-income, single-parent families, but have a strong work ethic. They have intense feelings of anger, hate, and injustice, which are often directed at all types of authority (Palmer, 1992).

These youth are recruited through schools and literature, and at dances. The gang's goal is to gain superiority and power through intimidation, which they do by their dress style and verbal insults. They dress in either green flight jackets or bomber-style leather jackets, army fatigues, suspenders, steel-toed boots, and T-shirts with White Pride logos (Palmer, 1992).

Symbols used by skinheads include the circled swastika, an upside down two-sided axe that is an antijustice symbol; a circled A that symbolizes anarchy; and a rifle sight that signifies violence. White or red-colored shoelaces may mean they are a supremacist, and yellow laces could mean they have recently injured someone (Palmer, 1992).

## African American (LA) Style Gangs

As noted earlier, Los-Angeles-type gangs have moved into communities across the United States in an effort to increase their membership. Palmer (1992) observed they often move into communities in which the youth are likely to be attracted to gangs but in which community members are likely to be naive and hence unprepared for the development of gangs.

Alienation from society and family is a significant risk factor for youth joining LA-style gangs. These gangs are often multiracial, though predominately African American, and attract both males and females for membership. As in other gang groups, members are individuals experiencing academic problems, are often truant, or are out of school due to suspension.

Their families, often headed by a single female head of household, reside in gang-impacted neighborhoods where gang affiliations regularly occur. Gang members recruit siblings. Teenage mothers and fathers teach their children gang signs and dress them in gang colors resulting in generations of youth who know no other life style.

Dress and color are important symbols of LA-style gangs. Gang members may adopt certain items of apparel that are worn in designated colors or in specific ways. For example, members of the African American Crips gang wear items of blue clothing to designate their loyalty. Their arch rivals, the Bloods, display red clothing. The colors differ, but what symbolizes gang affiliation is often the same, such as wearing work bandannas (do-rags) or colored shoelaces, and wearing trousers in a certain style. The do-rags are worn hanging out of a rear trouser pocket or tied around the head as a sweatband. Trousers are often worn loosely with the belt line near the mid to lower hip level; such a practice is referred to as *saggin*.

These gangs have their own brand of violence and revenge. Drive-by shootings are not uncommon as gang members fight over turf. Other activities include robberies and assaults using sophisticated weaponry, such as AK 47s and UZIs.

African American gang graffiti, which started appearing in the 1970s, have less flair and attention to detail, and the content emphasizes individual prowess (Jackson & McBride, 1987). African American gang graffiti frequently include statements of intent to harm rival gangs or specific gang members. Numbers 1, 2, 3 are often replaced with the terms *ace, deuce,* and *trey* (i.e., 52nd Street becomes five deuce; 83rd becomes eight tray or trey) (Suarez, 1987). African American gangs tend to use graffiti displays to announce their presence in a community and to list the roster of gang members, including real names and street monikers. It is, therefore, a source of information regarding a gang's strength and intentions in a community or school (Palmer, 1992).

## Hispanic or Cholo Street Gangs

Hispanic gangs began in the early 1900s in southern California. Rivalry developed between Hispanic immigrants from different areas, and gangs formed to defend what they saw as their territory. Then, as now, Hispanic gangs form alliances for purposes of strength. Intergang feuds and wars occur largely over territory as a result of some real or imagined transgression by a rival gang.

Reflecting a value in their culture is the belief that the gang is more important than the individual.

Hispanic or Cholo gangs are generational and comprised predominately of males from the family. Young males are known as *Pee Wees* or *'lil' Winos*. Anyone who lives past age 22 becomes a *veterano*. Although veteranos may participate in crimes, they are often the advisers to younger gang members. In addition, they assist by hiding members, disposing of weapons, and arranging meeting or party places for members. Even though gang membership occurs over several generations, this population is at risk for gang involvement because of their lack of assimilation into American culture and society.

Like other groups, Hispanic gangs have distinctive symbols, body language, and dress. A Cholo dress style might include a Pendleton shirt buttoned only at the top, cuffed khaki pants, a dark bandanna, an occasional hair net, and dark sun glasses. Tatoos may be found on various parts of their body indicating gang affiliation and the person's gang nickname. Not unlike other gangs, body stance is intended to intimidate. Arms are crossed as they stand with feet in a T shape or duck style.

The most highly developed graffiti are used by Hispanic groups. They are highly stylized and structured, requiring much effort to perfect to a level deemed worthy of the work now adorning walls of public and private buildings and structures throughout urban America. They are usually characterized by block-style lettering and clearly mark the territorial boundary or turf claimed by the gang (Palmer, 1992).

## APPROACHES TO PREVENTION

The best intervention for students' gang involvements is prevention. Major challenges for professionals in interfacing prevention, the individual person, and gang behavior include developing a positive self-esteem, developing coping skills, and providing some positive alternatives to gang involvement.

### Family

Like Hezekiah, many gang-impacted youth grow up by themselves and are, therefore, at risk to adopt as their families any group that provides them with a sense of belonging, importance, excitement, self-esteem, and approval. Parents need education and support in order to meet the demands they face every day in helping their children to live quality lives in which they have some hope that their future can be better than that faced by their parents. Many of the parent education courses available emphasize effective communication, interaction, and discipline techniques with children. Leaders may want to supplement such programs with Clarke and Dawson's (1989) book, *Growing Up Again*, which emphasizes an understanding of growth and development, self-esteem enhancement, and self-development for parents.

The TLC-TNT program (Tender Loving Care: Think 'N Try) was one of the first family mentoring programs in Portland, Oregon, involving youth in afterschool recreation activities. Two individuals engage students in activities between the critical hours of 3:30 and 9:00 p.m. They also mentor and support families providing structure and support to their children. In return for their involvement in this program, mentored high school youth are expected to become mentors/counselors to at-risk children in their community.

## Individual

The research has clearly indicated that with gang involvement comes increased violence and/or conflict in communities and schools. Two types of strategies may assist in addressing this phenomenon: conflict resolution education and dispute mediation training.

Prothrow-Smith (1987) developed one of the first conflict resolution curriculums for adolescents. This curriculum focuses on teaching participants how to communicate effectively so as to not escalate the conflict situation, to utilize problem-solving skills, and to maintain self-control through anger management techniques. The Portland Public Schools, for example, have reinstated the use of the Violence Intervention Program, an alternative for high school students who would otherwise be suspended. This conflict resolution program places heavy emphasis on anger management and attempts to influence individuals so they possess approaches to conflict that keep a situation from escalating out of control.

The use of peers as dispute mediators has gained popularity in many communities and schools. Selected students are trained in the areas of communication, leadership, problem solving, and assertiveness. In elementary schools they often serve as mediators on the playground. In high schools, they may be requested by individual students to resolve disputes occurring in interpersonal relationships. It is not unusual for teachers, police, and other community members to also receive dispute mediation training so they can help resolve the conflicts they may encounter in the course of their daily activities.

Northrup and Hamrick (1990) suggested that firearm safety courses be offered to youth and parents in communities and schools experiencing escalating violence and the use of firearms. These courses should focus on the dangers of firearms when they are not properly used or properly stored. The intent of such programs is to reduce violence, even though there are those who fear that talking about firearms may increase their use. To be most effective, such programs should begin in grades K-5.

Groups have long been an effective means of supporting and challenging youth to make positive changes in their lives (Moss, 1992). Developmentally, youth may be less inclined to discount or argue with their peers, but may do so with adults who try to influence or direct them. Therefore, the use of support and educational groups focusing on coping and decision-making skills has been recognized as helpful.

Rob Gould, founder of the Oregon Peace Institute and an advocate for a strong emphasis on decision-making skills, has observed in his work with gang members that many of them do not see themselves as having a choice (personal communication, September 23, 1994). When they do have thoughts and feelings, their first response is to discount and ignore them. Role-playing (by the facilitator) of typical gang member behavior allows the group to critique the leader as a way of indirectly and safely critiquing their own behavior and learning to trust their own judgment.

Self-esteem enhancement must be an important component of any gang prevention program. Juarez (1992) suggested that self-esteem interventions target males because of their dominance in gang activity. Alternative community support systems that enhance and support self-esteem development may want to focus on manhood development with some emphasis upon rites-of-passage programs that assist male teens in moving through adolescence into adulthood. Interventions to build self-esteem suggest that if a person likes himself or herself, he or she will be less likely to engage in activities that are destructive to self or to others (Wilson-Brewer & Jacklin, 1990). Self-esteem enhancement, however, is a long-term investment. It must begin early with healthy parenting, be nourished by the community, and consistently enhanced by schools through activities that give youth a sense of belonging and accomplishment.

The Self-Enhancement Incorporated (SEI) program partners with schools by placing its personnel on the school site. This program focuses on afterschool activities, weekend retreats, and vacation-time programs. Self-esteem enhancement is emphasized in all SEI activities through small group and self-development programs. These types of school/community partnerships assist schools in meeting some of the program needs relinquished as a result of fiscal downsizing.

## School

Schools are an important partner in any program that attempts to address prevention and gang activity. One reason is that school is the place where society expects all youth to come for education. Another is that the actions of this institution make a difference in whether or not our youth choose to become involved in gangs. Communities experiencing high dropout rates and/or suspensions contribute to gangs having access to and influence on youth. Reyes and Jason (1993) found that high schoolers who were at low risk for gang involvement were more satisfied with school and that their social group was predominately free of gang members. This study also found that an invitation for gang membership was the most potent factor in determining whether or not youth would become involved with gangs.

Jankowski (1991) found there were two reasons youth chose not to become involved with gangs. One reason was that gangs did not meet their current needs either due to their individual entrepreneurial efforts or because they were focused on the negative payoffs of gang involvement. These youth emphasized the discrepancy between their individual goals—for example, to move out of the community and own a business—and the activities/expectations of gangs. Additional schooling and training are necessary to accomplish such a goal. Involvement in gangs may result in death or never moving out of the community. Gang involvement, therefore, is not attractive. A program that helps students to set future goals is the I Have a Dream program. It is now following students, who could have gotten involved with gangs had they not been given the support and encouragement of this program, into high school.

A second reason involvement in gangs does not occur is because the gang does not invite a person for membership. This may be because the gang has enough members or because the individual is not deemed stable or trustworthy enough to be a member of the gang.

The implications of these findings for prevention programs are that programs need to begin early before an invitation for gang membership occurs, preferably in grades K-5. When programs do occur, they need to (a) emphasize the dreams, aspirations, and decision-making capability of the individual, (b) emphasize the consequences of gang involvement, and (c) encompass policies and procedures that welcome youth to schools and provide them with an interesting curriculum emphasizing individual success. The highly regarded Paramount Plan (Paramount, California) has developed a fifth-grade antigang curriculum that emphasizes constructive activities available in the neighborhood.

Tursman (1989) reported that Fremont High School in East Oakland, California, employed many strategies to interrupt the gang presence on campus. One strategy reported by the principal was that of sending subliminal, positive messages to students. A banner proclaimed that it was a friendly school. Even though in the beginning people laughed, teachers and students soon began to model this behavior, resulting in an environment that was inviting to students.

Drugs and alcohol are so intimately linked with gang behavior that any gang prevention program must address this topic. There are many curriculums available to schools and agencies. Choices made should reflect what is determined to be the goals of these educational efforts. Unfortunately, most drug intervention programs instituted in schools have not been effective in deterring drug use. Professionals have noted the compelling power of the three Cs (cars, clothes, and cash) on the choices students make. Effective programs must attempt to influence the power of these magnets. Therefore, in addition to saying "no," curricula should emphasize self-esteem, involve families and caring adults, and connect with the community.

Schools in communities where even minimal indicators of gang activity are discernible must adopt a policy of assertive vigilance and preparedness. Once a violent act occurs on a campus, a well-designed response plan must be activated to contain the disruptive influence of both the gang and the level of community fear concerning the perceived power of the gang. Essential components of effective response plans include the involvement of law enforcement officials and a detailed communications plan. The National School Safety Center (NSSC, 1988), stressed the need for the plan to "assume constant and consistent communications and designate responsibilities to specific staff members and administrators, in order to get the facts to the proper authorities, parents, and general public" (p. 33). It is essential to avoid the sometimes well-intentioned effort to withhold information to keep the situation under control or avoid creating hysteria. People want and need to know what happened, and more importantly, they want to know what is being done about it. Specifically, the NSSC recommended that schools

> Have a media policy worked out in advance. Spell out who will be the media contact, and make it clear that no one else will speak officially for the school or school district. Simultaneously keep school employees and students informed. The media contact person(s) will be the unofficial representative(s) who will serve as key communicator(s) in the community. In addition to the written media policy, school security departments need to:
>
> 1. *acknowledge the problem immediately and get help from local police and community groups;*
> 2. *educate security personnel;*
> 3. *establish informed communication networks with the kids;*
> 4. *institute a strict visitors/trespassers policy;*
> 5. *control school access points;*
> 6. *remove graffiti as soon as possible;*
> 7. *work closely with local police,* especially work to establish procedures whereby information may be shared;
> 8. *consider the use of cameras to take pictures of suspicious visitors or trespassers;*
> 9. *maintain a high profile:* consider using uniformed security personnel strategically in places to ensure maximum visibility; and
> 10. form or access a community network. (pp. 33-34)

Many individuals who have worked with gangs recognize the importance of having an informed school staff. Training that is offered should focus on how to recognize gangs by way of their symbols and colors, reasons why youth become involved in gangs, and why it may be important to examine scuffles and conflicts between students.

## Community

Hammer (1993), writing about youth violence and gangs, stated that new strategies are needed. These strategies must be broad based and involve the community. To be effective, they must stress education, employment, and the health-care needs of youth and their families.

Slovacek (1993), in the first report from Project Support, a Los Angeles School District program, suggested that comprehensive prevention or early intervention programs must address the following areas: (a) drug/gang policy awareness, (b) drug and gang prevention education, (c) racial/cultural sensitivity development, (d) afterschool alternative programs, (e) tutoring/mentoring models, (f) community service opportunities, (g) career awareness, (h) early intervention counseling, and (i) parent education.

Long Beach, California, has instituted a community-based gang prevention program that is coordinated by the parks and recreation department (Blancarte & Azeka, 1992). Youth 8- to 18-years-old who profile as at risk are targeted for involvement in gang-proof activities. The program structure involves 10 components that stand alone but are interdependent. In addition to a paid coordinator, trained service providers, and a commitment to program evaluation, this approach emphasizes antigang instruction, recreation programming, employment and development, peer counseling, parent education, and case management services for high-risk youth.

Another powerful intervention tool that started in Chicago involves parent or community patrols. The Chicago Intervention Network (CIN) emphasized strong neighborhood participation and partnerships among law enforcement agencies, social service agencies, and communities. One outcome of these coalitions was parent patrols. This idea has since been adopted and modified by other gang-impacted communities that realize the importance of neighborhood empowerment programs.

Important components of such programs involve a cooperative effort coordinated by a designated individual or group, participants who are divided into teams of five to seven who patrol targeted neighborhoods on 2- to 3-hour shifts, and distinctive clothing, such as jackets that designate team members. In communities where such programs have been successful, the patrols have been composed of police, local residents, and other volunteers. Community residents report increased feelings of safety and a reduction in vandalism, intimidation, and the presence of drugs.

In 1992 the Eleanor P. Eells award for program excellence was presented to Journey, a community-based program in Dallas, Texas, designed to reach young adults before they fall victim to gang participation and violence (Castellaw, 1992). Selected teens commit 1 year to this program and pledge nongang involvement. Components of the program include an initial camp experience that includes involvement in the ropes or challenge course, horseback riding, visitation by inmates from a nearby state prison, and an opportunity to see photos and videos of deadly drug-related violence, followed up with weekly support meetings. Others desiring to replicate this program have painfully discovered the importance of interviews and selective admissions for participants.

Police are important members of any community-intervention network. A community policing demonstration project was instituted in the state of Washington for the purposes of improving the image of police, promoting law-abiding behavior, and influencing youth to engage in work. Officers assigned to the project engage youth in brief, nonthreatening weekly interactions. This project has already demonstrated positive program outcomes for the officers, youth, and their parents (Thurman, Giacomazzi, & Bogen, 1993).

## INTERVENTION STRATEGIES

When it comes to impacting gangs, it is often better to talk about early intervention. Once gangs have established themselves in a community, removal of their presence is not easy because of the myriad issues that need to be addressed. Major issues that confront intervention efforts are violence, poverty, alienation, family disintegration, lack of recreation, disillusioned and unemployed youth, poor self-esteem, and schools that need restructuring to address issues of safety, uninviting curriculums, and disproportionately high suspension or expulsion rates. Obviously, no one answer addresses all of the elements. It is, therefore, not surprising that most who choose to discuss intervention talk in terms of cooperation and coalitions. As Juarez (1992) has noted,

> The impact of violence has far outstripped the resources and capabilities of the family, schools, church, and other traditional institutions to cope with the new set of demands that have been placed on them. There has been a severe eroding of the integrity of these institutions as primary institutions for socialization, effective social support systems, and advocates and/or buffers for disenfranchised persons. (p. 51)

### Family

One common denominator for youth in gangs is they have grown up in families exhibiting more family breakdown, more poverty, and poorer housing. Many of these homes are headed by a single parent, or there is a communication/culture barrier between the adult and youth generations.

Hezekiah was eventually placed in a safe house away from the city. This is somewhat like the witness protection programs in which a new identity and life are provided. Due to his status as a minor, Hezekiah was placed with a family offering him strong adult supervision and care. After 2 years, his new family experienced problems, and he was returned to the city. His grandmother was not able to influence him enough to keep him away from his gang family, and he was soon actively engaged in gang activities.

What Hezekiah's life and the experience of those who have intervened with gang-impacted lives suggest is that involvement must be long term. The magnets attracting youth to gangs involve the most basic of needs in their lives, the needs that families often provide: food, shelter, safety, security, belonging. In addition, gangs often provide youth with financial independence, though often at the expense of safety.

When society chooses to intervene on the influence of gangs, it chooses to disconnect youth from a situation in which there is a syntonic relationship, and one the youth does not desire to give up. It takes continuous and long-term efforts to dispel the influence of the gang family and restore the influence that best meets the needs of society and fosters positive development of the individual within the family.

The Touchstone Project is a unique partnership project in Oregon. State, county, city, and school personnel have united to serve families in Multnomah County. Caseworkers are assigned a caseload of 7 to 10 families with which they work to help solve problems and ensure connection with necessary services. These caseworkers are on call 24 hours a day and help families around such issues and barriers as jobs, income supplements, medical services, and parenting education. Caseworkers maintain contact with their families over several years—critical years for gang involvement and family support—and are now seeing youth move into high school.

The Touchstone Project provides the intensity and commitment necessary for change. The questions this program raises include What constellation of interventions makes a difference, if any? How long is enough? How do we match families and professionals? How much support must we give to the professional staff? Could we train neighbors or extended family members to intervene with these families and utilize professionals differently? How can we get entire communities committed to the raising of their youth?

## Individual

Hezekiah's life direction was initially changed due to the mentoring of personnel in an alternative school program. The school dropout literature has suggested that one of the most powerful factors influencing school completers versus noncompleters is an adult in their lives who constantly challenges them to set goals, supports their efforts, and encourages them in positive ways. The messages sent are direct and clear: "I believe in you. Don't mess up your life. Instead, set goals and do something!" Schools often set up mentoring programs aimed at matching at-risk youth with school and/or community adults who are willing to become involved in their lives in positive ways.

## School

Schools that find themselves impacted by gangs must act swiftly and firmly. Gangs can create chaos, promote violence and altercations against other students and faculty, and challenge safety and security needs. Those who have effectively met this challenge have implemented the recommendations promoted by NSSC (1988) and included in this chapter. They have also become involved in classroom antigang instruction, the education and promotion of peer counseling programs featuring conflict resolution and mediation, and cooperation with community programs identifying and intervening with youth.

The research done on school attendance and gang intervention has clearly pointed out the need to keep students involved in school. School suspension policies need to be reexamined. Hezekiah knew he could get suspended from school by engaging in certain activities, which he did. Then he was free to wander the streets, hang out with friends, and do gang business. In-school suspensions or community service projects may be helpful substitutions. Of course, when the safety and security of other students are jeopardized by the actions of another student, there can be no other alternative than to suspend from school. Then cooperation with community agencies may need to be enlisted so that the student is monitored while away from school.

An inviting curriculum can also help to increase school attendance and participation. One such curriculum is offered by the Portland Public School's Franklin High School. As part of this school's magnet program on law and government, the science department offers a forensic science curriculum that emphasizes how science is utilized to solve crimes. In cooperation with the local police, students are given opportunities to work on real crimes and get involved in procedures such as fingerprinting, DNA typing, hair analysis, blood typing, arson investigations, and crime scene searches. Another component of the program educates students, through the use of real cases, about the impact of drugs on the human body. The program attempts to deliver the clear message that crime investigations are becoming more sophisticated and thus crime involvement is risky business.

District-wide school policy in Portland, Oregon, has stated that the school does have the right to open and search lockers for the welfare and safety of all individuals involved. As part of the science unit, drug dogs are periodically involved in locker inspections. Students get the clear message that dealing drugs at school is risky and in violation of the law (K. Lange, personal communication, October 4, 1994).

## Community

Taking action is an important part of intervention. Communities where action follows the African proverb "It takes a whole village to raise a child" are experiencing success through diverse community programs. Many of the best intervention programs have been those for which individual institutions in the community have seen a need and have stepped in with an effort that they could manage.

Known as the first urban Boys' Town, the House of Umoja in Philadelphia provides boys with food, shelter, surrogate parenting, a small allowance, and employment opportunities. It has also sponsored outreach programs that broaden the involvements of participants in local cultural activities and international exchange programs.

The House of Umoja is best known for its involvement in negotiating an end to gang warfare in Philadelphia in 1974. Participation by members of 32 gangs resulted in agreements that helped reduce the number of gang-related deaths in the city from 43 in 1973 to 1 in 1977.

This project has inspired other communities to do what they can. One local church decided to focus on families and surrogate parenting. Members of the congregation were enlisted to become foster parents to kids in need of homes and a new direction in life. In this Redirections Project, kids in the community are identified and provided with placement options: an extended family member, foster parents, or a group home. Although they have been more into action than the keeping of statistics, this program has gained a reputation for the effectiveness of its efforts. An important observation is that participants need training on how to work effectively with these youth, and support so they do not burn out. Turning kids around is hard work and requires long-term commitment.

Those fortunate enough to get into drug treatment programs need to have support groups available to help them deal with the pressures of their environment at home, in their communities, and at school. On October 3, 1994, Peter Jennings, ABC World News Tonight, extolled the success of Drug Courts. In this program, drug-impacted adults go before a judge. Most are given the option of participating in a court-supervised intervention program consisting of counseling, education, drug treatment, and community service. The featured Oakland, California, program figures it has saved tax payers $3 million dollars and has a 50% completion rate. In a 3-year follow-up study, there was only a 10% recidivism rate for program completers. The success of this program points to the need for comprehensive, well-supervised intervention programs that give participants incentives to participate and that recognize the necessity for participants to have a structured program that monitors them for extended periods of time. Some estimates are that significant personal change takes from 3 to 5 years. This court-supervised program monitors participants up to 3 years.

Almost all intervention programs recognize the importance of having viable alternatives for youth during those unstructured hours and times when youth are not in school. Because of this, leisure/recreation programs have become important to effective community interventions. Rogers (1993) reported that in Los Angeles, youth were most apt to be killed during the early evening hours. Consequently, any program undertaken needs to address early evening activities, weekend activities, and summer-time involvements that appeal to a variety of ages and that are affordable.

## SUMMARY

Realistically, communities experiencing problems with gangs need to work both on prevention programs to help reduce the appeal of gangs and on intervention programs for those who "wanna be" involved. Gangs seriously drain resources and energy from the communities where they exist. In truth, a gang is as strong as the community allows it to be. The need for companionship, protection, excitement, affirmation, and security can be met either by gangs or by coalitions composed of youth-serving agencies, school personnel, neighborhood activists, and/or juvenile justice and law enforcement personnel. Communities must decide just how much power they are willing to surrender.

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# 13

# Adolescent Substance Abuse: Past, Present, Future

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In spite of our technologically advanced, modern society, America is fighting an age-old problem: drug and alcohol abuse. This is not a problem limited to adults. Significant percentages of youth and adolescents are experimenting with and becoming regular users of chemical substances, particularly tobacco, alcohol, marijuana, inhalants, and cocaine. The 1988 National Household Survey of Drug Abuse (National Institute of Drug Abuse [NIDA], 1989) found the following statistics as a result of sampling over 20 million 12- to 17-year-olds and over 29.5 million 18- to 25-year-olds:

| | 12- to 17-year-olds | | 18- to 25-year-olds | |
|---|---|---|---|---|
| | Ever Used | Current Use | Ever Used | Current Use |
| Cigarettes | 42% | 32% | 75% | 35% |
| Smokeless tobacco | 15 | 4 | 24 | 6 |
| Alcohol | 50 | 25 | 90 | 65 |
| Marijuana | 17 | 6 | 56 | 16 |
| Inhalants | 9 | 2 | 12 | 2 |
| Cocaine | 3 | 1 | 20 | 5 |

Abuse of these substances often results in harm not only to the individual teen but also to the community and society as a whole. For example, research has shown that use of alcohol is associated with 60% of all murders, 40% of all assaults, and 33% of all rapes and child molestation (Department of Health and Human Services, 1984; Tinklenberg, 1973). Not only are criminal justice systems experiencing the exploding impact of substance abuse but also health care systems. Millions of dollars are spent yearly in hospitals and special treatment programs to treat crises. In October 1986, the Drug-Free Schools and Communities Act was passed, and the Department of Education received $200 million for drug abuse education in the schools (Business Research Publications, 1987).

The questions facing us are Who are the adolescents most at risk for substance abuse? What steps can be taken to prevent or to stop teen substance abuse? Neither is easily answered. As an initial step in understanding the magnitude of and the issues involved in substance abuse, it is imperative to understand why teens turn to drugs, the physiological mechanisms of drug use, and the roles that parents, schools, and the community have in both prevention and intervention.

Prior to discussing these issues, we need to emphasize that drugs, in and of themselves, are not good or bad and that drug use is not necessarily the same as drug abuse. What influences value judgments of certain chemical substances is who takes them, for what purpose, when and where they are taken, and how much and how frequently they are taken. For example, the adult who has a beer or cocktail after work is seen differently than a teenager who has a drink after school because he or she had a hard day. One situation is viewed as relatively benign, but the other is viewed as *bad* and the user as *at risk* for abuse. Examining psychosocial, historical and legal, and physiological perspectives can help us better understand adolescent drug abuse.

## PSYCHOSOCIAL PERSPECTIVE

Avis (1990) classified drug use into three categories: experimental use, regular use, and heavy (intensive or compulsive) use. He defined experimental use as 10 or fewer experiences with a given drug. According to Jalali, Jalali, Crocette, and Turner (1981), although experimenters try drugs out of boredom or curiosity, in the hope of having fun or in response to peer pressure, they typically use drugs only in small amounts and infrequently. Usually they try only alcohol or marijuana and are cognizant of the difference between having fun and getting into danger. Teens only experimenting with drugs are more than likely not to develop serious drug problems.

Regular use, motivated by a desire to be social and to share pleasurable experiences with others (Avis, 1990), includes use that is circumstantial or situational and helps the person cope with a problem or some serious pressure. Avis cited students preparing for exams, truck drivers making a long haul, and body builders getting ready for a contest as examples of situational or circumstantial use. Avis did not seem to be particularly concerned about regular users, but we are concerned about teens who turn to alcohol or drugs when a life situation becomes too stressful for them. They are establishing a potentially dysfunctional coping style instead of learning more effective coping strategies.

A few unlucky teens, however, become compulsive users, and their lives and health are at risk due to their drug abuse. For these youth, drugs are an escape, a way to avoid discomfort rather than experience pleasure (Avis, 1990). Generally, they have poor relationships with their parents, with their conventional peers, and with school personnel, but have strong relationships with drug-using peers (Dembo, Blount, Schmeider, & Burgos, 1985). Intrapersonally, these youth often experience self-derogation, depression, and alienation that are acted out as rebelliousness, aggressiveness, independence, and risk-taking behaviors aimed at sensation seeking (Dembo et al., 1985). More and more of their time and energy is devoted to getting high and becoming connoisseurs of street drugs (Beschner, 1986). Although the data are not exact, approximately 4 to 5% of teens between the ages of 15 and 19 use illicit drugs regularly. This represents about 1 million teenagers—a staggering number.

Fields (1992) synthesized the research descriptions of the personality traits of alcoholics/addicts. These personality characteristics included (1) high emotionality, anxiety, and overreactivity; (2) low frustration tolerance; (3) inability to express anger adequately; (4) anger over dependence and ambivalence to authority; (5) low self-esteem with grandiose behavior; (6) compulsiveness; (7) perfectionism; (8) feelings of isolation; (9) dependence in interpersonal relationships; (10) hostility; (11) sexual immaturity; (12) rigidity and inability to adapt to changing circumstances; (13) simplistic black-and-white thinking; (14) immaturity in interpersonal relationships; (15) depression; and (16) sex role confusion.

According to a review of the literature by Dembo et al. (1985) on the etiology of drug use, the user who is White is most likely to be using alcohol and/or marijuana. Ethnic minority youth (Black, Native American, and Hispanic) are more likely to use alcohol and drugs other than marijuana. Although no gender and socioeconomic differences appear to exist, use seems to escalate until around age 19 when a decline occurs. The earlier use starts, the greater the potential for deviant behavior, self-derogation, and feeling rejected by family and peers. In response to feeling rejected, a social climate that accepts and supports drug use and tolerates, if not endorses, other social problems is sought.

This is the extreme scenario, but many youth are rapidly moving toward the compulsive user status. Still, most have been able to stay clean or have merely experimented with a substance. Research is beginning to address why some become abusers and others do not. Research has also begun to examine sociocultural issues related to substance use.

Ethnicity is gaining increased attention as myths about minority group members being the highest users and abusers are being debunked. However, the image of African-American or Chicano/Latino adolescents at crack houses high on drugs or drunk on the street is a portrayal all too often provided by the media (Dryfoos, 1990). This media presentation of ethnic minority adolescents perpetuates the commonly held stereotype that ethnic populations have the highest use and abuse rates of alcohol and drugs. Well-meaning television commercials that have adolescents say "no" to drugs frequently have an ethnic protagonist. The inaccurate message that drug use is primarily an ethnic minority problem is reinforced.

Much of the current research has indicated that ethnicity is not a contributing factor in predicting the use or abuse of alcohol or drugs (Dryfoos, 1990).

In a review of the substance use research in *Sociological Abstracts*, *Psychological Abstracts*, and *Social Science Index*, Rebach (1992) found that Whites tend to use alcohol and most drugs at higher rates than do Asians, Blacks, or Hispanics. American Indian students had the highest alcohol use rate. Blacks had the highest abstention rate from alcohol, and Black and Hispanic youth began marijuana use at a later age and were less likely to become heavy users than were their White counterparts.

Reviewing alcohol problems among ethnic minority groups, Lex (1987) found heterogenous drinking patterns and specific psychological, medical, and social consequences for each group. Lex suggested that treatment programs adopt multidisciplinary approaches for all racial groups. Most of the research on substance use and abuse, however, has not focused on race or ethnicity and is typically not longitudinal in nature (Jillson-Broostrom, 1993). Similarly, racial or ethnic factors are often not included in adolescent prevention or intervention programs. Wallack and Corbett (1990) stressed that prevention programs need to incorporate "a combination of approaches affecting different aspects of the political, social, and cultural environment, in addition to the individual" (p. 17). "Simply stated, intervention programs designed for particular groups *need* to be developed within the sociocultural world view within which they are applied" (Schliebner & Peregoy, in press).

For ethnic minority substance users, Rebach (1992) noted that health problems are a major consequence. For example, esophageal cancer and cirrhosis of the liver are the most frequent health problems associated with alcohol use among ethnic minorities (Herd, 1988; Rogers, Goldkind, & Goldkind, 1992). Alcohol-related health problems among American Indians occur at rates 2 to 5 times that of the general population (Rebach, 1992). Another consequence of substance use among ethnic minorities is a disproportionately high number of violent crimes and arrests (Rebach, 1992). Minority group members are at higher risk for arrest, for being victims, or for committing violent crimes (Gary, 1985; Harvey, 1985).

Because the racial or ethnic adolescent is highly influenced by family and extended family, (Ho, 1987; Marin, 1991), effecting change utilizing the support of the family is essential (Goddard, 1993). For this reason, prevention and intervention programs need to utilize the family system in changing drug use patterns.

## HISTORICAL AND LEGAL PERSPECTIVES

The first attempt to control alcohol/drugs was through taxation: whiskey was first taxed in 1791 and opium in 1842. The real fight against narcotic use began in 1914 when it was estimated that 1 in every 400 Americans was addicted to opium or its derivatives. Between 1919 and 1929, 75,000 narcotic arrests were made, and 25,000 of these were physicians and druggists for prescribing drugs (Ray & Ksir, 1987). To protect themselves, those in the medical professions began to refuse to treat addicts. Because addicts could no longer get a maintenance dose of their drugs legally, the illicit drug trade began to flourish, charging 50 times more than the legal medical price.

The Marijuana Tax Act, passed in 1937, brought marijuana under the same legal control as cocaine and other narcotics. Anslinger, appointed director of the Federal Bureau of Narcotics in 1932, claimed that marijuana was the "assassin of youth" and that it caused insanity, murder, rape, and impotence (Mandel & Feldman, 1986). One of his most memorable images was of "rosy-cheeked, innocent girls, lured to inner-city neighborhoods by a misguided sense of excitement, waking up after smoking marijuana for the first time with the realization that they had been debauched by lower-class males" (Mandel & Feldman, 1986, p. 23).

In reality, heroin, not marijuana, was gaining popularity. To counteract the growth of heroin use, the Narcotics Drug Control Act was passed in 1956. The Act mandated tough penalties for every offense except first-offense possession and sanctioned the death penalty for anyone caught selling heroin to a minor.

With the 1960s came a shift in the type of drug used and an increase in drug usage. The federal government was so concerned with the problem of youth drug use that President John Kennedy convened a White House Conference on Drugs in 1962. The 400 conference participants coined the term *drug abuse*, advocated the use of civil commitment to allow medical treatment of drug abuse, and fostered the initiation of projects to address the social problems of delinquency and poverty.

Between 1964 and 1970, youths across America were becoming drug conscious. Studies on LSD were being conducted at Harvard, marijuana was openly smoked on many college campuses, and for the first time there were active prodrug advocates (Mandel & Feldman, 1986). Drugs were used for getting in touch with self, for improving socialization, and for enhancing senses and realms of awareness. The hippie counterculture blossomed and peaked with the Woodstock Festival for peace and love. Across the United States, young middle-class White youth were becoming drug users as they discovered the information gap (which some called the generation gap) between the reality of drugs and what they had been told (Mandel & Feldman, 1986, p. 28). This was the period of the civil rights movement, sit-ins, freedom rides, mass demonstrations, and the beginning of the Vietnam War and draft resistance. In many respects, it became youth and counterculture supporters against the adult establishment that had started to react negatively to the counterculture.

By 1970, the flower children of 1967 had no economy to support themselves. Many had trouble handling the drugs they had experimented with and were now burned-out speed freaks or heroin addicts. New drugs were hitting the streets, and the potency and effects were unknown and often frightening. There were overdoses, admissions to emergency rooms, and bad trips. There was a drastic increase in arrests among Whites, and inner-city minority youth shifted away from using heavy addicting substances to more controlled use of drugs.

President Richard Nixon proclaimed a War on Drugs and increased the federal antidrug budget from $40 million in 1969 to $750 million in 1973, with half to go to law enforcement and half to treatment programs. The War on Drugs was an uphill battle as drug use among youth had become normalized and was no longer seen as deviant behavior. Each year in the 1970s, 49 to 57% of those arrested for drugs were under the age of 21. Arrests for marijuana varied from 62 to 72% teenagers. Arrest rates were highest for Black males (Mandel & Feldman, 1986).

The present law of the land is the Controlled Substances Act of 1970. Besides expanding the role of community mental health centers and Public Health Service hospitals in the treatment of drug abuse, it authorized the development of drug education materials and workshops for professionals as well as school personnel. It also established a schedule for maximum penalties for manufacturing/distributing drugs and for possession of drugs.

Drug-related arrest rates among White youth is declining. In 1983 it was approximately half of the 1978 rate. In their study of seniors' use rates between 1975 and 1983, Johnston, O'Malley, and Bachman (1984) reported decreases both in use of marijuana in the last 30 days (in 1978, 37% responded that they had smoked marijuana in the last 30 days, and in 1983, only 25% answered in the affirmative) and in the daily use of marijuana (in 1978 this was 11%, and in 1983 it was 5.5%). Similar decreases were found in the use of sedatives, inhalants, tranquilizers, and hallucinogens. In contrast, the use of cocaine and stimulants has steadily increased.

Cocaine became the drug of the 1980s and of the yuppie society. Until recently, "coke" was considered reasonably safe and nonaddictive and appeared to be *the* drug for the health conscious, upwardly mobile, politically conservative generation. The drugs of the 1990s appear to be methamphetamine derivatives such as ecstacy, ice, and crank (Witters, Venturelli, & Hanson, 1992). Surprisingly, heroin use is again on the increase among youth who still seem to believe that they are invincible and will not become addicted to whatever chemical substance they are sampling. Heroin use for high school seniors was 5% according to a 1990 study by the National Institute of Drug Abuse (Witters et al., 1992). Additionally, heroin users often initiate use of the drug via sniffing then move to injecting into a muscle (skin popping) or vein (mainlining) (Witters et al., 1990, p. 236).

That our older society still disapproves of drugs and is willing to enforce drug laws is evident. Although youth may not be alarmed at someone smoking a joint or possessing marijuana, the *Hutto v. Davis* (1982) ruling testified to the feeling of those representing the nation. Arrested for possession of 9 ounces of marijuana, Davis was convicted on two counts of possession with intent to sell and sentenced to 40 years in jail. Although he appealed his sentence as being cruel and unusual punishment, the U.S. Supreme Court ruled against him (Inciardi, 1986).

Teens and their parents need to be aware of their state's laws regarding drug use and the legal rights of minors when arrested. The public library is an excellent source for information about state laws related to alcohol and drugs. The rights of minors established by *In re Gault* (1967) include a right to notice of the charges, to counsel, to confront and cross-examine witnesses, privilege against self-incrimination, to a transcript of the legal proceedings, and to an appellate review. Minors do *not* have a right to bail or to a jury trial.

## A PSYCHOPHYSIOLOGICAL PERSPECTIVE

In addition to knowing the psychosocial and historical aspects of drug abuse, to be at all knowledgeable about substance abuse we need a basic understanding of how drugs affect the body. No matter what drug is taken—aspirin for a headache or cocaine to feel high—the drug goes through several phases. First, it is taken into the body (*absorption*) and *transported* to the part of the body where it will exert its *action*. The body then *metabolizes* the drug, which stops its action, and finally, the body *excretes* the drug. For some drugs these phases occur in a predictable manner and in a short time span, but for others, the process is erratic, occurring over an extended time period (Julien, 1978).

Drugs are taken into the body in several different ways, the most common of which is by mouth. When drugs such as alcohol, tranquilizers, and stimulants are swallowed, they are absorbed through the intestinal walls into the blood stream. Marijuana, nicotine, and inhalants are smoked/inhaled and enter the bloodstream through the lungs. Heroin is injected directly into the vein (mainlining). Snorting, the preferred method of using cocaine, allows it to be absorbed through the mucous membranes. Drugs deposited under the skin (skin popping) are directly absorbed into the blood stream.

The blood carries drugs to all parts of the body. Because *all* drugs have side effects, we cannot always be exactly sure what physiological and behavioral reactions will result from taking a drug. Effects of a drug depend on many variables including the type, potency, and purity of the drug, the contaminant used to cut the drug, the personality of the user, and the social environment in which the drug is taken. In addition, the individual's physiology must be considered, especially the nervous system.

The nervous system is made up of the central nervous system (CNS), the somatic system, and the autonomic nervous system (ANS). The CNS, comprised of the brain and the spinal cord, is responsible for information processing, memory, learning, and activity coordination. Senses come into the CNS, and motor nerves go out. The somatic system interfaces with the CNS and controls *voluntary* actions. In contrast, the ANS, which is made up of the sympathetic and parasympathetic systems, controls *involuntary* actions such as the heart beating, digestion, and breathing. Many drugs influence the ANS (Ray & Ksir, 1987).

The chemical messengers that carry information throughout the body can be classified as hormones or neurotransmitters. Chemical substances affect our glands, which release hormones directly into the blood, while neurotransmitters serve as signals within the CNS. Although drugs do affect the release of hormones, they have their major impact on the neurotransmitters and the CNS. The major neurotransmitters that interact with psychoactive substances are acetylcholine, norepinephrine, dopamine, serotonin, gamma aminobutyric acid (GABA), and endorphins. Neurotransmitters serve as a lubricant in the synapse between the axon of one neuron and the receptors of another. Neurons form chemical pathways in the brain. Just as different neurotransmitters are affected differently by various drugs, so are parts of the brain. Drugs disrupt neural transmissions; however, the exact process is a matter of speculation (Lewis, Dana, & Blevins, 1988).

An overview of some of the major structures of the brain may help to clarify the intricate interactions among drugs, neurotransmitters, the brain, and behavior. The brain structures include

1. the cerebral cortex, which controls reasoning, language, and sensory discrimination;
2. basal ganglia, which maintains good muscle tone;
3. the hypothalamus, which is involved in eating, drinking, temperature, and sex drive;
4. the limbic system, which is involved in emotions, physical activity, and memory for location;
5. the medial forebrain bundle, which is the pleasure center and tell us when something feels good;
6. the brainstem, which controls respiration and vomiting; and
7. the medulla oblongata, which is the seat of aggression. (Goldberg, 1982).

When the chemical pathways in these various regions of the brain are invaded by drugs that excite, inhibit, or block the appropriate actions of a neurotransmitter, the brain and related behaviors are influenced. For example, cocaine is believed to block a receptor's reuptake of norepinephrine and dopamine, which results in a feeling of euphoria. Tranquilizers block the reuptake of dopamine in the basal ganglia, which results in muscle relaxation. Tranquilizer abuse can result in muscle rigidity. Similarly, dopamine in the medial forebrain bundle is affected by psychoactive drugs and increases the sense of experiencing pleasure. Nerve gas inhibits the metabolization of acetylcholine in the brainstem and causes respiration to slow or to cease (the brainstem is the site of action). Taking PCP or angel dust, which influences the neurotransmitters in the medulla oblongata, can result in violent and bizarre aggressive behaviors.

Although research on the interaction of neurotransmitters, drugs, and behavior is just beginning to uncover these complex relationships, we do know that psychoactive drugs affect the chemical pathways. It is evident that drugs do not simply make the user feel better. They interfere with the normal functioning of the nervous system as well as other organs in the body. When drugs are abused or overused or combined, the effects can be deadly. The two greatest dangers are respiratory failure and cardiac arrest. Those who combine alcohol with sedatives, barbiturates, or tranquilizers are particularly at risk for respiratory failure: they may just stop breathing.

Thus to be a wise user of drugs, if the choice is made to use drugs, the user should be aware of the multiplicity of effects created by drugs. Every drug has side effects, and research has not yet discovered the many influences these side effects can have physiologically or psychologically.

## INDIVIDUAL DRUGS

Alcohol, tobacco, marijuana, and inhalants are the four most commonly used drugs by adolescents, although it should be noted that other substances are also abused and that stimulant and heroin use is increasing among youth. As the following overviews of these drugs show, there is no typical profile of a teen drug abuser. The adolescent user comes from all socioeconomic levels, all ethnicities, and both genders.

### Alcohol

Alcohol was the first drug regulated in the United States in 1791, and there is some evidence that alcoholic beverages have been used since 8000 B.C. (Ray & Ksir, 1987). America's one attempt at alcohol prohibition in 1920 failed as many citizens obtained alcohol illegally. The Eighteenth Amendment, the Prohibition Amendment, was repealed in 1933. The trend has been to relax the laws on intoxicating beverages. With the steady increase in deaths due to driving under the influence (DUI), Congress authorized the withholding of federal highway funds from any state that did not raise its legal drinking age to 21 by 1986. DUI is the leading cause of death among teenagers.

The two alcoholic beverages most consumed by Americans are beer and wine. It is estimated that 24 gallons of beer, 2 gallons of distilled spirits, and over 2 gallons of wine are sold per year for each man, woman, and child, with sales of wine steadily increasing. An alcohol beverage rapidly gaining popularity among youth is the wine cooler (Avis, 1990). Because it looks like soda and has a sweet, fruity taste, teens do not realize that it has a high alcohol content (6% compared to 4% for a can of beer). Montgomery (1988) reported that 42% of sixth graders believed that their friends had drunk wine coolers.

Fournet, Estes, Martin, Robertson, and McRary (1990) reported that 17% of fifth graders reported drinking alcohol, although experimentation typically began between the ages of 13 and 15. In their national study of seniors, Johnston et al. (1984) found that 93% of these seniors reported having drunk alcohol, 5.7% indicated daily drinking, and 41% claimed occasional binging. Robinson, Gloria, Roth, and Schuetter (1993) found that almost 24% of the college students they studied reported first drinking alcohol in middle or junior high school and that the earlier the drinking began, the heavier it was by college years. The single best predictor of drug abuse is early age of onset of use (Ungerleider & Seigel, 1990).

When consumed, alcohol functions as a depressant. Because it is almost completely metabolized and the rate of oxidation is slow, alcohol has a long duration of action that cannot be controlled (Ray & Ksir, 1987). When the blood alcohol level (BAL) is .04%, indicating that one or two drinks have been consumed, there is lowered efficiency of the cortex such that there is lower alertness, relaxation of inhibitions, impaired judgment, increased heart rate, and usually a sense of feeling good (Avis, 1990). As the BAL increases, judgment ability declines, reaction time is slowed, and both sensory and motor capabilities are impaired. Most states define drunkenness at a BAL of .10. Intoxication is officially reached at .20 BAL, a stupor at .30, and .35 is the minimal level that can result in death.

Like any depressant, alcohol affects the CNS and in large doses can cause respiratory failure and death. It is also known that the vomiting reflex (controlled by the brainstem) can be activated at .12% BAL unless the drinking is slow and steady, causing a depression of this reflex. Along with these and other brain changes, there are cognitive and behavioral changes. There is a lower level of blood flow to the brain, which possibly lowers levels of oxygen, nutrient use, and waste removal. In addition, there are changes in cortical functions that result in behavioral changes. The more rapid the intake of alcohol, the greater the behavioral changes as the drinker becomes less inhibited.

When a woman drinks heavily during pregnancy, fetal alcohol syndrome often results in physical and behavioral abnormalities in the fetus. Among women who are the heaviest drinkers, spontaneous abortions are twice as likely (Ray & Ksir, 1987). Physical damage due to alcohol use is rare in adolescents just because they have probably not been abusing for a long enough period of time. With prolonged abuse, gastritis with hemorrhaging and inflammation of the pancreas can result. Bleeding, severe vomiting, and changes in the blood can cause hospitalization. Chronic alcoholism in adults can result in chronic liver disease, inflammation of various nerves, and impaired memory (Schonberg & Schnoll, 1986). Withdrawal symptoms for teens who have been heavy alcohol users include tremors, perspiring, agitation, disorientation, and brief seizures.

Alcohol is the most significant substance abuse problem among adolescents, yet little is known about it scientifically. It negatively affects cognitions, behaviors, and our body and has been linked to increased crime, violence, and suicide. It is known that an adolescent becomes addicted to alcohol more rapidly than an adult with the same drinking patterns.

## Tobacco

Although cigarette smoking has decreased over the last 40 years, it is still relatively prevalent among adolescents, with about 35% reporting tobacco use (Robinson et al., 1993). Adolescent girls are the most frequent users of cigarettes.

Nicotine, the primary active ingredient in tobacco, is toxic and addictive. When nicotine is absorbed, it is carried on droplets of tar (Avis, 1990). Absorbed nicotine is distributed rapidly throughout the body and is even found in breast milk. The half-life of nicotine is 2 hours; however, regular smoking results in an accumulation of nicotine. This accumulation allows the smoker to remain exposed to the effects of nicotine 24 hours a day, including while asleep (Benowitz, 1988).

Cigarette smoking causes sympathetic nervous system arousal. Smokers have increased heart rates and because of the carbon monoxide in cigarette smoke, lose 15% of the oxygen-carrying capacity of their blood. The walls of the arteries become less flexible, which is thought to increase the severity and risk of hardening of the arteries. Because there is decreased blood flow to the skin, smokers appear to age more rapidly than nonsmokers. Smoking also seems to result in a decrease in appetite because taste buds are deadened. The relationship between smoking and cancer is well established, yet even the warning placed on the package fails to deter smoking. As any smoker will agree, it is difficult to stop smoking, which attests to the strong addictive nature of the nicotine.

Of recent concern has been the negative effects of secondhand or side-stream smoke. Research has shown that nonsmoking spouses of smokers have a higher rate of lung cancer than spouses of nonsmokers. Young children and infants exposed to side-stream smoke have more respiratory and asthma problems (Avis, 1990). Smoking mothers are more likely to have babies who die from sudden infant death syndrome and have babies with fetal tobacco syndrome, resulting in numerous health and behavioral problems.

Many people are reluctant to view tobacco as addicting. However, the Surgeon General's Report of May 3, 1988, detailed how and why nicotine results in addiction. It also pointed out that the pharmacologic and behavioral processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine.

## Marijuana

Although marijuana is about equal to alcohol in popularity, even less is known about its effects (Padina & Johnson, 1990). From 1937 to 1971 it was legally classified as a narcotic, and in large doses, it can produce hallucinogenic effects. By the late 1960s, however, society was far more concerned with the more potent substances appearing on the black market.

It appears that there has been a decline in marijuana use among teens. Johnston, O'Malley, and Bachman (1989) reported that use among high school students has steadily decreased from a high of 60.4% in 1979 to 33% in 1988.

Marijuana comes from the cannabis plant and gets its psychoactive effect from tetrahydrocannabinol (THC). Various grades or types of marijuana include sinsemilla, which contains as much as 8% THC; hashish, which can be up to 50% THC if made into hash oil; and street marijuana, which is 2 to 5% THC. When marijuana in smoked, the THC is rapidly absorbed into the blood. While having a sedative effect and causing an enjoyable, dreamy high, marijuana alters the metabolization of serotonin and dopamine. Schonberg and Schnoll (1986) cited considerable research on the negative effects of marijuana on brain, cardiovascular, pulmonary, endocrine, and psychological functioning. Because it causes short-term memory loss and depresses the ability to learn, heavy marijuana smoking has been linked to the amotivational syndrome in which youth are lethargic, lack motivation, and are content to do nothing. This becomes a special concern in youths who use marijuana before or during the school day because they are impairing both their desire and ability to learn. The long half-life of marijuana means that a daily smoker may be continually high because the marijuana is never out of his or her system.

Many of the effects of smoking marijuana are similar to those of drinking alcohol. These include lowered secretions of sex hormones; impaired motor coordination, reaction time, and sensory perception; and decreased ability to follow moving objects. With poorer motor coordination and distorted time and distance perceptions, people under the influence of marijuana present the same safety risks when driving as do people driving under the influence of alcohol. In fact, marijuana is considered by many to be the second leading cause of teen death in car accidents.

Although no current research has indicated that a physical addiction to marijuana occurs, the existing research on the effects of marijuana is in its infancy. There is increasing belief that marijuana affects the lungs in a manner similar to tobacco, which often results in cancer. Chronic smoking of marijuana does impair air flow in and out of the lungs, and only long-term research will be able to verify the relationship between marijuana smoking and cancer. As Ray and Ksir (1987) have noted, there is no area of science where emotion has played such a heavy and influential role. There are many advocates for marijuana, and many who believe that every evil related to marijuana whether backed by research or not should be publicized. Initial research has shown that its effects are not harmless, but neither are they devastating. The primary concerns are for pregnant women using marijuana and for the psychosocial development of adolescents who engage in daily heavy use.

## Inhalants

Young adolescents between the ages of 11 and 15 are the primary users of inhalants, although use of inhalants has steadily declined with the increase in marijuana use. Airplane glue, gasoline, cleaning fluids, and aerosols are the compounds sniffed by these young teens. Each of these compounds contains volatile hydrocarbons that cause a strong short-lived euphoric high. Symptoms of inhalant use are similar to those of alcohol use and include "lack of coordination, restlessness, excitement, confusion, disorientation, difficulty in walking (ataxia), delirium, and coma" (Schonberg & Schnoll, 1986, p. 54). Repeated use can result in giddiness, dizziness and hallucinations; long-term use can cause brain, liver, kidney, and nerve damage (Schonberg & Schnoll, 1986).

A syndrome called *sudden sniffing death* can occur when inhalant abuse is immediately followed by excessive exercise and stress. Although young teens may enjoy the giddy high that is connected with sniffing, chronic use can result in brain damage. Acute intoxication can lead to death due to cardiac arrest or unconsciousness resulting in asphyxia (Avis, 1990).

## CASE STUDY: THE STORY OF SUSAN

The case of Susan, an adolescent user, provides a working illustration that will facilitate our discussion of prevention and intervention strategies:

Susan is a 16-year-old Caucasian female in the 11th grade. Due to her parents' recent turbulent divorce, she comes directly home from school to prepare dinner and care for her 10-year-old sister and her 8-year-old brother. As the family's financial status has decreased, Susan's mother has been forced to work overtime and has to leave her children alone more than she wants. When she was 15, Susan began smoking to fit in with her peers at weekend parties. Now, however, her use of cigarettes has nearly doubled—to a pack of filtered cigarettes per week.

A couple months ago, she met her current boyfriend, Alan, and tried marijuana with him and his friends. Since then she smokes marijuana with Alan about once a month and has gone home drunk on two occasions. Her parents responded by not allowing her to get her driver's license, and now she often rides home with friends who have been drinking. When Susan's mother found a beer bong in her closet, Susan claimed not to know what it was and to be only keeping it for friends. At the last weekend beer party, Susan experimented with ecstacy. Its powerful effects frightened her, and she hasn't tried it again.

At school, Susan's performance has steadily declined over the past couple of months. She regularly ditches classes and hands in her schoolwork late. To cover her conduct, she intercepts the answering machine messages from school that report her tardiness and absences. Susan has also dropped out of band and has been seen smoking outside the school building on many occasions. Her teachers report her as becoming mouthy and "having a bad attitude about school."

When confronted about her behavior, Susan reflects a sense of invulnerability common to teenagers. She reports that "Nothing will happen to me. Everyone is doing it."

## PREVENTION AND EDUCATION

Concerned adults in Susan's life are asking themselves two main questions: Why did Susan start using drugs? How do we intervene to decrease or stop the substance abuse that is already occurring? The two primary milieus for prevention are schools and the family (Robinson, 1989). In addition, there are a variety of community-based treatment programs that address substance abuse.

### Schools

The primary responsibility for substance abuse prevention and education has fallen on the public schools. Yet research (Goodstadt, 1980) has shown that just giving students drug education and information (often misinformation) has failed to deter drug use. During the 1970s, educators tried to fight drug abuse by employing affective education approaches such as parent effectiveness training (Gordon, 1970), the DUSO kit (Dinkmeyer, 1973), and the magic circle technique (Ball, 1974). None seemed to have a deterring impact on adolescent drug use.

In 1982, Horan and Williams demonstrated that general and drug-specific assertiveness training positively influenced junior high school students' willingness to use alcohol and marijuana. At a 3-year follow-up, these students reported less actual drug use and demonstrated higher levels of assertiveness.

Tobler (1986) conducted a meta-analysis on 143 adolescent drug prevention studies. Review of the studies revealed five major prevention strategies: knowledge oriented only, affective strategies only, social influence and life skills approaches, knowledge plus affective strategies, and alternative strategies. In the last decade, a variety of educational programs have attempted to address the teen drug problem from a single dimension. One of the most noted single-faceted prevention programs, the "just say no" approach advocated by Nancy Reagan, tells adolescents to refuse to try drugs. This, however, is a unidimensional, simplistic approach to a multidimensional, complex problem. It asks students to respond behaviorally without addressing the cognitions or feelings often involved in making such a decision. Although it gives a student permission to decline peer pressure, it has been deemed a program that "doesn't work" (Dryfoos, 1990, p. 168).

Another popular media prevention strategy has been the commercial that compares a brain on drugs to an egg sizzling in a frying pan. The problem with this parallel is that if an adolescent experiments with drugs and does not experience adverse effects, the message does not seem applicable. This type of commercial fosters an information gap between the perceived reality of drugs and the disaster the message conveys.

Those curriculum prevention programs that have been considered effective utilize multidimensional strategies. An example is Botvin's (1986) Life Skills Training Program, designed for junior high students and presented by trained teachers and students from the 11th and 12th grades. The program encompasses affective, cognitive, and behavioral components that include short- and long-term consequences of drug use (i.e., biofeedback after smoking cigarettes), critical thinking, decision-making skills, anxiety coping skills, social skills to resist peer pressure, and self-improvement.

The Growing Healthy program is another widely used prevention program that utilizes multiple components. Research on this health education program has evidenced a reduced use of alcohol, drugs, and cigarettes among adolescents (Dryfoos, 1990). The program, which is promoted by the National Center for Health Education (National Difussion Network, 1986), is for kindergarten through seventh grade children. It combines general health issues with reading, arts, sciences, and physical education to address issues of body systems, safety, nutrition, hygiene, fitness, mental health, and healthy life styles. By using audiovisuals, models, workshops, and students' parents, the program strives to include the school, parents, and community in prevention efforts.

The weakness of most prevention programs in a lack of formal evaluation. After meta-analyzing 350 prevention programs, Bangert-Drowns (1988) noted that just over one third presented any kind of evaluation data—with some of these having questionable methodology (Dryfoos, 1990). Most commercial curriculum packages—including Children Are People, All Stars, 8:30 Monday Morning, D.A.R.E., Lions/Quest Program—Skills for Adolescents, Project Pride, and Get High on Yourself—are not supported by empirical research and have not been systematically evaluated. However, although they need to be objectively evaluated, most of these programs attempt to address the drug problem from multiple perspectives.

Regardless of the school-based curriculum chosen, it should address the primary factors involved in the etiology of substance abuse. These factors include peer use of illicit substances (Kandel & Yamaguchi, 1985), peer pressure (Brook, Whiteman, & Gordon, 1983; Brook, Whiteman, Gordon, Nomura, & Brook, 1986), early antisocial behavior (Hawkins, Lishner & Catalano, 1985), troubled families (Hawkins et al., 1985; Shore, 1985), cultural influences (Schliebner & Peregoy, in press; Trimble, Bolek, & Niemcryk, 1992), and deficient intrapersonal traits such as positive self-concept. As pointed out by Dryfoos (1990), incorporating behavioral, cognitive, and affective strategies is important in prevention efforts. In addition, Wallack and Corbett (1990) have called for a "broader, more comprehensive, and multifaceted approach to prevention that take[s] a variety of societal and cultural factors into account while also focusing on environmental factors" (p. 5).

Other school-based, noncurricular prevention programs include in-house counseling or support services. Dryfoos (1990) reviewed the popular student assistance program (SAP) first developed and implemented by Ellen Morehouse. This program utilizes full-time professional counselors to provide alcohol and drug abuse prevention and intervention services to 11th and 12th graders. Services specific for students who are performing poorly academically, consultation with parent and community to develop effective means for dealing with substance use problems, and group, individual, and family counseling are offered. Because SAP counselors are typically employed by external organizations, they are not under the same confidentiality and time constraints as school guidance counselors. Evaluation research of SAP approaches has indicated significant reductions in alcohol and marijuana use along with significant increases in academic performance.

## The Family

Including the family is essential when implementing a broad-based prevention program. Sometimes the family contributes to adolescent alcohol or drug use, however. The abusive family, the alcoholic family, a single-parent family, a family in which the children are latch key children, a blended family, and a family with inconsistent limit setting and rules for behavior have been most consistently documented as contributing to teen drug use.

Although it is often difficult for parents to admit, substance abuse does not just suddenly occur and does not happen in a vacuum. It is often the result of many factors, including feelings of low self-esteem and inadequacy, ineffective coping skills, and poor decision-making skills. Most parents try to raise their children with love and caring; however, too many teens have not learned to love themselves or how to cope constructively with problems. Instead, drugs help them escape their problems. Glickman and Utada (1983) found a dramatic degree of conflict, misunderstanding, and disagreement between parents and teens who were seriously involved in drugs. These teens reported that their parents objected to their friends (77%), were disappointed in them (69%), complained about them (64%), and did not trust them (63%). For these teens, the quality of their relationship with their parents was poor and communication was defensive and certainly not honest.

If parents suspect that their child is using drugs, the National Institute on Drug Abuse (NIDA, 1984) advises them to tell the child about their concern and why the drug is harmful. In addition, parents need to communicate that they are opposed to any drug use and that they intend to enforce that position. Parents need to be "*understanding* (I realize you're under a lot of pressure from friends to use drugs.); *firm* (As your parent I cannot allow you to engage in harmful activities.); *self-examining* (Are my own alcohol and drug consumption habits exerting a bad influence on my child?)" (NIDA, 1984, pp. 4–5). What parents should not be is sarcastic, accusatory, sympathy-seeking, and self-blaming because these behaviors tend to make a child defensive and likely to tune the parent out (NIDA, 1984).

Consider the following scenarios with Susan. When Susan comes home drunk from a weekend party, the reaction of both her parents serves to increase, decrease, or effect no change upon her substance use and at-risk behaviors. Although the parents are divorcing, they need to provide a unified front in dealing with Susan. If this is not possible, then the mother needs to act on her own. If her parents become accusatory, Susan is most likely to become defensive and perhaps blame the drinking on the fact that her mother is never home anymore and on the divorce. If Susan's parents accept her accusations, she will be able to diffuse her responsibility for drinking and perhaps increase her drinking as she now has a justifiable reason. If the parental reaction is explosive and overly exaggerated, Susan is most likely to deny her behaviors and further communication will be stilted with Susan feeling misunderstood. If Susan's parents ignore the situation or attempt to explain away Susan's reactions, Susan is most likely to continue her behavior as no consequences ensue. So what is a parent to do? If Susan's parents can genuinely assure her that they understand the need to fit in or be part of the group, and allow Susan to take responsibility for her drinking while receiving a firm yet fair and consistent reprimand, the journey toward decreased substance use will have begun.

A confrontation with a child regarding drugs can be difficult and charged with emotions; however, the more parents can remain calm, open, loving, and firm the better. Parents need to listen to their children and not just give advice. One of the keys to helping a child grow up is to teach them how to make responsible decisions, to accept the consequences of those decisions, and to love themselves. This cannot be accomplished quickly; it is a slow process nurtured by parental support, love, concern, and understanding. Parents need to know the differences between firmness and punishment. Children respect fair limits that take into consideration their maturity level. Consistency in limit setting helps a child understand acceptable parameters for behavior and what will consistently earn approval or disapproval. Parents need to be in charge in a loving supportive manner. Although adolescence is a time of seeking independence, autonomy, and self-identity (Miller, 1989), most teens still need and want some parental direction as well as nurturing and caring.

## INTERVENTIONS

If intervention rather than prevention is required, it often occurs in a more structured setting such as a treatment program. Treatment programs vary in type, setting, and services. Settings include short-term inpatient crisis care, inpatient programs, day care programs, residential treatment, halfway houses, and outpatient treatment programs. Although all programs make extensive use of group and individual therapy, they also "require some parental and/or familial involvement in the program and attempt to provide family counseling" in an effort to focus on the "underlying problems" in the family milieu (Kusnetz, 1986, p. 151). The more actively involved and supportive the family, the greater the chance of recovery for the substance abuser.

Motivation is also a key ingredient to stopping alcohol and drug abuse. More successful adolescents recognize that they have a problem and want to change (Kusnetz, 1986). Those teenagers who are apt to be less successful are referred by the criminal justice system, have used drugs for a longer time and are more immersed in the drug culture, come from families where the adults are substance abusers, and have histories of violence and gang involvement (Kusnetz, 1986). Regardless of the background of the abuser, motivation to change on the part of the teen and family involvement are the keys to improvement.

## Family-Based Interventions

As noted earlier, parents and family play an important role in adolescent substance abuse interventions as they primarily shape an adolescent's environment. Specifically, parents have the ability to control both positive and negative reinforcers, to provide support and encouragement as teens move through developmental stages, and to provide an atmosphere of acceptance within the family. As the teen's substance use and the family environment reciprocally affect one another, parents are instrumental in bringing the family to counseling or to participating in other intervention strategies.

***Recognition of the problem.*** One of the most difficult and important components in intervening with an adolescent is parental recognition of a substance use problem. Recognition of the problem and the need to request help may trigger feelings of intense anger, hurt, betrayal, or failure to emerge. Acknowledging that their child is using alcohol or drugs and that assistance is needed does not imply parental failure but instead reflects caring and parental involvement. Denying the problem may fulfill a short-term need, but continued or escalated use is most likely to occur.

Parents can look for changes in mood, attitude, grades, peer group, extracurricular activities, and interactions with parents and family members as indicators of possible substance use. In our case example, Susan exhibited numerous warning signs: fallen grades, dropping out of band, a beer bong in her closet, withdrawal from her family, and coming home drunk. Her parents responded by not allowing her to drive; however, this intervention did not decrease her substance use.

When parental discipline designed to change a teen's substance use behaviors is not effective, a family systems approach to counseling is recommended. As noted earlier, an adolescent's substance use is not an arbitrary or isolated event. Using a family systems framework, counselors focus on both the adaptive and maladaptive exchanges among family members and between the adolescent and his or her environment (Ho, 1987). Emphasis is on improving the transactions that occur within the family, using the family as a natural support system, and using the life events and experiences of the family system (Ho, 1987).

In Susan's family, the focus should be on saving the family and each member rather than on saving the marriage. In the safety of the counseling setting, each person can explore his or her role as a family member and how Susan's behaviors influence herself and the family as a whole.

***Communication.*** A second recommended component of at-risk substance abuse intervention focuses on communication in the parent-child relationship. Teens often feel that parents criticize, make demands, try to control, and rarely listen to what they have to say. Further, many adolescents believe their parents do not understand their pressures, concerns, and, most importantly, feelings. The need for effective communication is important in light of Rhodes and Jason's (1988) findings that weak family relations, perceived lack of support, and high number of family conflicts are related to higher levels and severity of use.

Communication interventions should target both the parent and the child by effecting communication at a more meaningful level. The content of what the adolescent is saying is important, but parents also need to listen for the feelings that accompany the message (Daroff, Marks, & Friedman, 1986, 1990). For instance, if Susan tells her mother that she is never home anymore, the feeling underlying the message is perhaps one of loneliness, fear, or abandonment. Hearing the emotional message is often difficult, and parents may find a third party helpful in enhancing communication with their teen. A counselor can point out ineffective communication styles (e.g., intolerant, judgmental, defensive), teach more effective communication strategies, and serve as a model for both parent and child.

Effective communication enhances a positive parent-child relationship. Rutter (1987) has indicated that a good parent-child relationship serves as a buffer between the environment and the child and subsequently increases the child's self-esteem. As good self-esteem and effective communication skills are both buffers against substance use, a more positive outcome for the adolescent may emerge. Additional family factors that promote a positive (or protective) outcome for children include rewarding children for independence with moderate risk taking, encouraging them to assume responsibility, and modeling examples of helpfulness and caring (Werner, 1984). Parents often have to be taught how to do these in a way that is helpful to the adolescent and promotes maturity and good decision making.

***Behavior replacement.*** A third component in family-based intervention has a behavioral framework. The goal is to replace maladaptive substance use behaviors with healthy adaptive behaviors. Behavior replacement as discussed by McWhirter, McWhirter, McWhirter, and McWhirter (1993) is based on two assumptions. First, behaviors teens are likely to engage in (e.g., afterschool activities, going out with friends, talking on the phone) can serve to reinforce those behaviors teens are less likely to engage in (e.g., cleaning their room, making curfew, completing chores). Second, logical consequences for behaviors encourage adolescents to take responsibility for their behaviors.

The first step in a behavioral intervention is to determine what the adolescent considers to be positive reinforcers. These may include telephone privileges, peer outings, peer interactions, allowance, or use of the car. Each positive reinforcement needs to be salient and available and to be allotted in graduated portions by the parent.

Next, parents need to set up logical consequences to be applied firmly and consistently. This firm and consistent limit setting accompanied by a reasonable discussion provides teens with the structure and respect they need (Daroff et al., 1990). Again, logical consequences differ for each adolescent. Being grounded for a weekend may seem drastic and earth shattering for one teen but endurable or irrelevant for another. To avoid teens challenging parental authority, inappropriate and unacceptable behaviors must be clearly defined and specific at the start of the behavioral intervention.

In the case study, a positive reinforcer for Susan could be use of the family car. This privilege could be granted to her only for appropriate and acceptable school and weekend behaviors.

One approach to setting unambiguous consequences for behaviors is behavioral contracting between parents and the adolescent. This allows for the specific determination of rules and consequences while providing a catalyst for clear communication. Behavioral contracts specifically state the acceptable and unacceptable behaviors and the resulting consequences of each. Duration of the contract needs to be feasible (i.e., weekends versus forever). Initial success of a contract increases the adolescents' self-efficacy and sense of responsibility. Contracts can be renegotiated as competence is achieved. A possible contract between Susan and her parents might include specific and detailed lists of unacceptable behaviors such as no drinking at Friday night parties, no ditching classes, and not mouthing off to teachers. Privileges such as telephone use, peer interactions, and dating need to be linked to specific acceptable behaviors such as consistent school attendance and making weekday and weekend curfews. A set of target behaviors required before she can have driving privileges might include a consistent school attendance for a specific time period, a clearly specified improvement in grades, or agreement to attend individual counseling for a certain number of sessions.

### Individual-Based Interventions

As an alternate to or in addition to family counseling, individual counseling is recommended. This counseling can be obtained from community mental health agencies, hospitals, and private practice therapists. Some HMOs provide both inpatient and outpatient drug and alcohol counseling, although often for a limited number of sessions. An experienced counselor who is nonjudgmental and represents a stable parental figure who can provide a safe and trusting environment is most likely to elicit the adolescent's willingness to participate.

Exploring the teen's perceptions of home, school, and peers can help the counselor to identify the motives, beliefs, and behaviors contributing to the adolescent's substance use. Counseling should address self-esteem, self-efficacy, anger, hopelessness (e.g., "nothing is going to get better"), and the need to belong. As each of these areas is attended, building a teen's self-confidence, assertiveness, and ability to make healthy decisions becomes a realistic and attainable goal.

### School-Based Interventions

Parents are often not the first to recognize that their teenager is having a substance abuse problem. Teachers and school counselors are often the first to recognize substance use behaviors. They are key players in curbing adolescent substance use because early detection is important for the best chance at decreasing drug use.

Teenagers struggle with developmental concerns of boundary and identity issues (McKim, 1991); therefore, it is essential to gain their trust for interventions to be successful. A respected school counselor or teacher who is perceived as open and receptive is most likely to have success (Fields, 1992). These trusted relationships may allow for disclosure of family, peer, or school difficulties as well as use of substances. Fields identified the factor of caring as the key ingredient to establishing such relationships. Teachers and school counselors provide a critical resource for a nurturing and understanding learning environment as school is often a refuge from the home environment (Werner, 1984).

Once adolescent users are identified, notifying and establishing a working partnership with the parents to prevent further drug use is necessary. Depending on parental cooperation and school counselor availability, workshops can be conducted after normal school hours or on the weekends for students and their parents. Information and skill-based training, such as assertiveness training and decision-making skills, can aid the adolescent in making informed decisions about substance use (McWhirter et al., 1993). Although these workshops are not intended to serve as individual or group counseling, they can help teens understand the situations that lead to their substance use and the consequences of continued use/abuse (McWhirter et al., 1993). School counselors can use innovative strategies such as talks by recovered abusers, movies, group outings, and drug-free parties. In addition to workshops, the school counselor can serve as a liaison to the parents regarding the teen's behaviors and academic performance. For the necessary changes to occur, it is essential that the teen understands the counselor's role and that the counselor is acting as an advocate, not as a snitch or as another adult who does not understand.

The school counselor can also locate and coordinate appropriate academic and vocational opportunities for the student in the school system as well as in the community. Alternative school programs such as early release for work-study programs, vocational school training, or specialized school programs may provide adolescents with an avenue to continue their education in an environment more receptive to their interests and needs. Adolescent school refusal problems related to substance use are often solved by entrance into alternative school programs (e.g., early release, individually paced programs).

Another school-based intervention targets the naturally occurring peer groups. As teens most typically trust and relate to their peers, peer support and education groups are effective ways of relaying information to teens. Peer discussion groups of adolescents who are committed to staying off drugs allow teens to discuss their experiences and difficulties with peer pressures and wanting to fit in. Adolescents can find validation in knowing they are not alone in their experiences and feelings. Similarly, myths can be dispelled by finding out that not everyone is using drugs. Most importantly, the group can help foster healthy peer relationships that promote self-growth. Programs such as Students Against Drunk Driving (S.A.D.D.) are an example of this type of intervention. Involvement in extracurricular activities such as sports or clubs can also serve as an informal source of support for youth.

## Community-Based Interventions

Unfortunately there are few treatment programs for adolescents, and those that exist are generally costly. McWhirter et al. (1993) identified five community-based programs presently available for teens: drug-free programs, residential treatment, therapeutic communities, day-care programs, and aftercare.

*Drug-free programs* are usually outpatient programs within a residential program. Activities range from individual and group counseling to challenging experiences. *Residential treatment* facilities are inpatient facilities that focus on long-term recovery. They require the adolescent to live on site and attempt resocialization to the community through learning new life skills in a controlled learning environment. *Therapeutic communities* are a similar residential type of treatment. These programs are for teens who are recovered substance use offenders referred from the juvenile court system. Focusing on extinguishing substance use, therapeutic communities rely on peer influence and group action to change attitudes and destructive behavior. *Day-care programs* typically are less structured than residential programs. Their services usually include academic learning and counseling as well as supervised social activities. *Aftercare* programs target the adolescent who has been discharged from treatment. The premise of these programs is that treatment is a lifelong process.

Other community-based interventions often involve the law enforcement system working in collaboration with the community to intervene with adolescents who are using substances. Police are encouraged to talk with the parents of the adolescent arrested for a substance use offense. Also, a subsequent penalty of community service with police-sponsored activities such as D.A.R.E. or police league teams is recommended. Police, parents, schools, and community task forces can work together effectively to design communitywide prevention and intervention programs to combat adolescent substance use. By organizing neighborhood task forces, the responsibility for preventing, and intervening in, substance use is jointly shared by individuals, schools, and communities, and chances for success are greatly enhanced.

Other community resources for teens include Boys and Girls Clubs and community YMCAs. These organizations provide alternative activities for teens to help deter substance use. Often these programs are staffed by caring adult volunteers and recovered users who want to provide healthy, productive, and positive role models for teens.

## SUMMARY

It should be remembered that "no single strategy has demonstrated long-term impact" (Wallack & Corbett, 1990, p. 15) on adolescent alcohol and drug abuse. Prevention of substance abuse is a shared responsibility among the individual, the family, the school, and the community. Both prevention and intervention programs need to be directed toward teens' behaviors, feelings, and thoughts (Dryfoos, 1990) within a culturally and socially congruent environment (Lex, 1987; Schliebner & Peregoy, in press; Trimble et al., 1992). Although we may never totally stop substance use, preparing our children and adolescents to be wise decision makers may help them avoid becoming substance abusers.

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# 14

# No Where to Turn: Homeless Youth[1]

*Melissa Stormont-Spurgin and Lee Ann De Reus*

The extensive research conducted with impoverished children confirms that homeless children are at high risk for academic and behavioral problems in school (Butler, 1989; Lewis & Doorlag, 1987; Reeves, 1988). It is important to address the unique needs of homeless youth in school because in addition to being poor, homeless children possess salient characteristics that set them apart from other children (Eddowes & Hranitz, 1989; Gonzalez, 1990; Harrington-Lueker, 1989). As such, homeless children may not be well accepted by teachers or peers.

Homeless children's differences in appearance, behavior, and ability demand tolerance and flexibility from teachers and school administrators. It is evident that the educational needs of homeless youth attending school warrant interventions from teachers, counselors, and administrators—who must become aware of their available resources. A homeless child's educational or social problems may require either minor or more extensive instructional adaptations (Gonzalez, 1990).

Conservative estimates indicate that at least 500,000 children are homeless in the United States (National Coalition for the Homeless, 1994b). Thus school systems must be prepared to address the needs of homeless youth. Sadly, most homeless youth are consistently ignored both in society and the schools. Before understanding and change can occur, we must understand the demographics of homelessness.

This chapter first describes homelessness, both demographically and more descriptively using a case study. Next, the chapter delineates preventive measures society must take to avoid the problem of homelessness. Finally, interventions to help increase the numbers of homeless youth in the classroom and address their educational needs are explored.

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## HOMELESSNESS DEFINED

Homelessness means having a primary residence that is a public or private shelter, emergency housing, hotel or motel, or any other public space—including public parks, cars, abandoned buildings, or aqueducts (National Coalition for the Homeless, 1990). Being homeless means more than not having a fixed place to sleep. Homeless people have nowhere to put the items they cherish, things that connect them to their past. They have typically lost contact with their family and friends and often must uproot their children from school. Homelessness means suffering the frustration and degradation of living hand to mouth, depending on the generosity of strangers or the efficiency of a government agency for survival.

At least 1 million families in the United States are homeless, with incidence increasing at a rate of 25% a year (National Coalition for the Homeless, 1990). From the most recent statistics available, it is clear that the faces of the homeless have changed drastically since the days of the White, male, alcoholic, skid row bum. According to the National Coalition for the Homeless (1993), 40% of the homeless in the United States are families and 25% are children. Within these families half of the children are under the age of 6. They may never go to school, or they may enter school for the first time at a late age. Conservative estimates have indicated that one in five homeless children are not currently in school (National Coalition for the Homeless, 1994a). Unfortunately, children are the fastest growing group of homeless (National Coalition for the Homeless, 1994a). In New York City alone, the number of homeless family members living in shelters increased 11% in a 6-month period of time (National Coalition for the Homeless, 1994b).

The following case of a homeless family illustrates the problems that the children might face in school:

> It was 3:00 a.m. At a local gas station a man was trying to bum $5 worth of gas off the attendant as his family waited, shivering, in their junky car. The attendant obliged the family and called a local homeless shelter asking if they would let the family stay even though their doors were closed for the night. The children arrived at the shelter, hungry and cold. Their parents tucked them in and stayed up for a while chatting with the volunteers. They were homeless because of one bill they could not pay, their electric bill. They tried to survive in their trailer without heat, light, or hot water, but it was too hard on their children.
>
> The children woke up and ate breakfast. Their clothes were wrinkled. They were dirty and extremely tired. They went to school after less than 3 hours of sleep. What will their teachers think when they fall asleep in class? How will they get food for lunch? What will their peers think? They went to school dirty, wearing the same clothes as the day before. Contributing to the problems of their physical diversity, what could these

> homeless children talk about with their peers? They have had to grow up too fast. Their worries are not the same as other children's. They are worried about their next meal and where they will seek shelter. However, their needs are the same as other children's. They need a home and all the securities that come with it. They also need an education.

The family's story reveals what the consequences of homelessness may be for youth in the classroom. In addition, the homeless youth who attend school typically do not have school records, immunization records, a permanent address, transportation, school supplies, gym shoes, appropriate clothing, a full stomach, a neat appearance, or clean clothes (Gonzalez, 1990). These problems can serve as major road blocks for achieving an education.

Homeless youth also face many problems outside of school that inhibit their physical and psychological well-being. They may live in a roach-infested welfare motel (possibly surrounded by crime and drug deals) or an overcrowded, noisy shelter. They often have chronic health problems for which they do not get medical care. They also do not have health care when they get sick.

In addition to these physical deficiencies the children may also experience inconsistency in adult supervision (e.g., shelter rules vs. parents' rules) and have no place to do homework, no privacy, no resources, no television. Further, homeless children may be frequently exposed to domestic violence (Eddowes & Hranitz, 1989).

According to Maslow's hierarchy, needs for shelter, security, and food must be attained before higher order needs such as psychological and self-actualization needs can ever be considered (Maslow, 1968). Homeless children are not getting the most basic needs fulfilled, and their psychological health is also at stake (Harrington-Lucker, 1989). These children may experience numerous emotions related to their homelessness including embarrassment, anxiousness, fear, low self-esteem, depression, suspiciousness, and insecurity (feelings of lack of control) (Harrington-Lucker, 1989). These children's adult worries make it understandable that they might not care about completing their homework. Homeless children are also frequently uprooted from place to place, each time having to adjust to a new school and face peer rejection. These conditions may explain a lack of enthusiasm towards participating in the academic setting.

## PREVENTION: CAUSES OF HOMELESSNESS

The best way to prevent the problems of homeless youth is to prevent homelessness. Homelessness however, is a complicated social issue that requires a multilevel approach:

> There are no cheap or easy solutions to the problems of homelessness. At varying levels of analysis, homelessness is a housing problem, an employment problem, a

> demographic problem, a problem of social disaffiliation, a mental health problem, a substance abuse problem, a family violence problem, a problem created by cutbacks in social welfare spending, and a problem intimately connected to the recent increase in persons living below the poverty level, as well as others. (Wright, 1988)

Thus permanent affordable housing is only part of the solution. Ending homelessness is a matter of providing people with opportunities for housing, a decent wage, health insurance, treatment for addictions, and education. For homeless youth, an education may be the answer to breaking the cycle of homelessness.

## Causes of Homelessness

When a person or family becomes homeless it can typically be attributed to an interaction of poverty, unemployment/low wages, increased costs of housing/lack of low-income housing, reductions in federal and state entitlement programs, and failure of the health care system (National Coalition for the Homeless, 1993).

***Poverty.*** Since 1980 there has been a 46.7% increase in the number of persons living in poverty, and by 1992 the number of poor Americans exceeded 36.9 million or 14.5% of the population (National Coalition for the Homeless, 1993). By 1992 standards, *poor* meant a family of four with an income of $14,335 or less. It is no wonder that families are the fastest growing segment of the homeless population, and for these families, meeting basic daily needs requires an inordinate amount of time, energy, and perseverance. On the average, a homeless family spends 37 hours a week trying to obtain food, clothing, shelter, child care, medical care, public assistance, and job training (HomeBase, 1993).

***Unemployment/low wages.*** The basis of employment in the United States has changed dramatically over the past 20 years from a highly paid manufacturing-based economy to a low-paid service-based structure. The result of this shift is reflected in the growing numbers of homeless as people are faced with unemployment and underemployment. Nationally, the United States lost 882,000 manufacturing jobs between 1980 and 1988. Although new jobs were created during this time period, 88% were in retail and restaurant work (HomeBase, 1993). Unemployment is considered a leading cause of increased homelessness (National Coalition for the Homeless, 1993). In June 1993, a 7% unemployment rate translated in to 8.9 million workers out of work (National Coalition for the Homeless, 1993). In addition, the number of people out of work but still looking for jobs for 6 months or more has continued to remain high, with 1.7 million people considered as long-term unemployed in June 1993 (National Coalition for the Homeless, 1993). Once people become homeless, it is increasingly difficult to find a job because without a home they do not have a permanent address or telephone number to include on job applications.

Work alone does not mean a family will be able to rise out of poverty, however. Overall 60% of new jobs created since 1979 pay less than $7,000 a year (HomeBase, 1993). By the end of the 1980s, 49% of employed tax payers (47.2 million people) had annual incomes below $20,000 (Bartlett & Steele, 1992). Working full time at a minimum wage job that pays $4.25 an hour in 1994 equals a gross monthly salary of $680. After paying rent a family is hard pressed to stretch their remaining dollars to pay for food, let alone insurance, telephone, medical expenses, clothing, and school. If there are preschool-aged children in the home, it is often not economical for both parents to work because his or her wages are likely be devoted entirely to child care expenses. For a single parent, holding a job may not be an option unless the child attends school or has free child care. In addition, most low paying jobs do not include health care benefits. Thus the serious illness of one family member can lead to tremendous financial hardship or homelessness.

***Increased costs of housing/lack of low-income housing.*** Federal standards specify that housing should not exceed 30% of a household's income. However, almost two thirds of renters who are poor pay 50% or more of their income for housing (Dolbeare, 1991). In fact, the fair market rent for a one-bedroom apartment is unaffordable for at least one third of renters in all 50 states. Although federal, state, and local housing assistance programs are available to the low-income community, only one third of low-income renter households receive such assistance (Dolbeare, 1991).

In a housing study of 175 households in a medium-size Midwest community, respondents paid an average rent of $300. This represented 36 to 48% of their income, which ranged from $7,500 and $9,999. Of those households, only 15% received any type of financial housing assistance (De Reus, MacDermid, & Targ, 1991). Other barriers to obtaining housing for the homeless reported in this study included an inability to afford a deposit for an apartment, and a lack of housing vacancies, transportation to look for housing, and child care.

The Federal Housing Act of 1949 was created in efforts to provide a decent home for every American family. In 1968, housing legislation was passed to create 6 million units of federally subsidized low-income housing. By the late 1970s only 2.7 million had been built (National Coalition for the Homeless, 1990). The prospects of additional low-income housing in the future are dubious. It is estimated that a loss of 1 million units will occur over the next 20 years due to subsidy expirations, opt-out provisions in Section 8 contracts, and losses due to physical or financial collapses (HomeBase, 1993).

***Reductions in federal and state entitlement programs.*** National and state policy changes since the Reagan era of the 1980s have greatly impacted people with low incomes. Federal housing programs designed to create or subsidize low-cost housing were cut as much as 75% under President Reagan's administration (National Coalition for the Homeless, 1990). As many states have faced severe fiscal distress, they also have made drastic cuts in programs that assist the poor. State programs such as Aid to Families With Dependent Children, general assistance benefits, and Supplemental Security Income for elderly poor and the differently abled were cut more sharply in 1990 and 1991 than in any year since the early 1980s (Center on Budget and Policy Priorities, 1992). In 1992, 44 states cut or froze their AFDC benefits. Similar reductions occured in 40 states in 1991. These reductions were more than any decreases since 1981. General assistance benefits were also reduced or eliminated in 22 states from 1991 to 1992. Twenty-six of 27 states either froze or cut Social Security benefits for poor elderly and disabled recipients during 1992 (Center on Budget and Policy Priorities, 1992).

These cutbacks have left holes in the safety net. Without these benefits to fall back on, many people are destined for economic hardship and homelessness.

***Failure of the health care system.*** The health care system in the United States is severely lacking. Over 40 million Americans have no health care insurance, and there is a shortage of substance abuse treatment programs and community facilities for people who are chronically mentally ill (National Coalition for the Homeless, 1993). For homeless people with addiction, the traditional substance abuse treatment methods are inadequate. Issues of poverty, physical and mental illness, and remediating skill deficits are rarely included as a part of treatment but are blatant barriers to a homeless person's potential life of stability and self-sufficiency (National Coalition for the Homeless, 1993). The programs that do exist are unable to meet the service demands. In one 1991 study of local treatment programs for the homeless, results indicated that 80% of the local programs were forced to turn away homeless clients seeking help. In addition, there exists a lack of supportive, alcohol- and drug-free housing. In the state of Massachusetts, only 185 openings were available in drug-free housing for the 25,000 homeless people that received treatment annually (National Coalition for the Homeless, 1993).

People with chronic mental illness also have a shortage in appropriate housing, relegating many to the streets. During the 1960s, deinstitutionalization became the treatment policy for serving the mentally ill. As a part of that policy, 2,000 federally supported community mental health centers were planned, but less than 800 were actually established (National Coalition for the Homeless, 1993). Although the increase of homeless people is often attributed to the deinstitutionalization of persons with mental illness during the 1970s, the federal government has established that this movement was not the primary cause of increased homelessness. In fact, the dramatic increases in the homeless population occurred much later than the 1970s (National Coalition for the Homeless, 1993). It was the decade of the 1980s, characterized by poverty and a lack of affordable housing, that resulted in growing numbers of people finding themselves on the street.

## INTERVENTIONS

Hoping that the government will recognize these tragic problems and change inadequate policies is unrealistic. The sad truth is that thousands of families are destined for homelessness. Thus homeless families, individuals, communities, and schools must work together to design and implement effective interventions that will ensure homeless youth are receiving the education they need and deserve.

### Parents

To ensure that their children are receiving an appropriate education

1. parents need to know their rights within the educational system, including their children's right to receive an appropriate education as stated in the Stewart B. McKinney Homeless Assistance Act of 1986;
2. parents need to contact any local school system to receive these data if they have difficulty obtaining the information by themselves. They could also contact a local shelter, social service agency, or church for assistance in obtaining the information; and
3. parents could work as an advocate for other homeless families and inform them of their educational rights.

This list of suggestions for parents may be idealistic considering the magnitude of the problems associated with homelessness. Therefore, schools must take a leadership role in bridging the gap between homeless shelters and the schools. Schools are an important socializing agent, second only to the family (Kauffman, 1993). As such, school personnel need to consider what effect they will or can have on every individual student's future success in life. Counselors, teachers, and administrators may not be able to influence the quality of a student's life outside of school. However, they can influence a student's life once that child is seated in a classroom. As Kauffman (1993) wrote, "In our culture, success or failure at school is tantamount to success or failure as a person..." (p. 225).

### School Counselors

School counselors' knowledge and sensitivity to serving homeless children in the schools makes them the best coordinator of resources for these individuals. The complex emotional and educational needs of homeless children match the training and work of school counselors. School counselors could coordinate efforts to educate teachers and administrators on the characteristics and educational needs of homeless children. For example, the school counselor should be considerate of the transient nature of homeless students. When homeless children arrive and leave a school, counselers should

1. be aware of informal assessments available to obtain quick information about the child's ability levels in different areas;
2. arrange an initial meeting with the family to stress the importance of school for the child; and
3. provide closure if the child is leaving by establishing a special time to clean out a locker and desk, and say good-bye. (Indiana Department of Education, 1988)

Models cited in the literature help identify accommodations that teachers, administrators, and communities can institute with counselors serving as the coordinator of such programs. Counselors need to help teachers modify their classroom to accommodate homeless children's behavioral and social difficulties by being aware of models that have been effective for these children (Gonzalez, 1990). Counselors need to be knowledgeable about the services (state and local) available for homeless children and help coordinate community efforts to advocate for the educational needs of these children. Counselors could also work with administrators to develop or institute programs such as programs to increase retention of students (HomeBase, 1993). Further, counselors could help arrange for independent study options and other special adaptations for students who are homeless, which will possibly increase their opportunities for success in school (HomeBase, 1993).

## Teachers

Teachers should have inservice training on homelessness and classroom modifications (Eddowes & Hranitz, 1989). This could be organized by school counselors and administrators. It is particularly important that teachers are aware of the diverse needs of homeless youth. This individualization for children who are homeless may mean that teachers have to change or adjust their conceptualizations of what constitutes success in school. For example, two studies have documented what elementary (Hersh & Walker, 1983) and secondary (Kerr & Zigmond, 1986) teachers believe are important student characteristics or skills for school success. These critical skills are that the student

- follows established classroom rules;
- listens to teacher instructions;
- complies with teacher commands;
- does in-class assignments as directed;
- produces work of acceptable quality given his or her skill level;

- has good work habits (e.g., makes efficient use of class time, is organized, stays on task);
- makes her or his assistance needs known in an appropriate manner;
- expresses anger appropriately; and
- behaves appropriately in nonclassroom settings and respects property and the rights of others.

If we consider the children in the case of the homeless family described earlier in this chapter, it is easy to discern that achieving these competencies may be problematic for students who are homeless. Thus the following suggestions for teacher interventions are focused on academic adaptations, behavioral management, emotional well-being, and educating other students on the characteristics and problems faced by children who are homeless.

Some of the interventions are relatively easy and require only a small time commitment from teachers. Others, however, may be too demanding for some teachers. Counselors should help teachers decide which of these suggestions are feasible for them. Counselors could then employ some of the modifications themselves (e.g., teaching social skills 1 day a week).

***Academic adaptations.*** Teachers should administer quick informal assessments to students who are homeless. Teachers need to develop an assessment and work folder for the student that can be easily transferred to another school. In order to do adaptations, a teacher needs to analyze informal assessment data and begin instruction in various areas accordingly. In addition, there are many small changes a teacher can make in terms of homework assignments. If students have difficulty completing written work, a teacher can adjust the amount of work required by students or change the output requirements (e.g., a child could recite a story into a tape recorder instead of writing it out). Teachers should modify assignments for a child who has no place to work after school (Eddowes & Hranitz, 1989) because homework may get damaged or lost.

A teacher can also increase the production of students who are homeless by simply changing the classroom environment. Teachers can have a private area in the classroom that is the children's place to keep their work. Students should be allowed to post their work in a special place to help them take pride in what they have done.

***Behavioral management.*** Homeless children need positive structure. Teachers need always to set up conditions in which these children can succeed and then praise them accordingly. In addition, teachers should give clear, concise rules and be consistent when enforcing them (Eddowes & Hranitz, 1989). Teachers should also take the time to explain to the children why the rules are necessary. Teachers then need to inform shelter officials and parents of all rules and assignments. Reinforcement or other plans can be arranged for children who need encouragement to complete their homework (Eddowes & Hranitz, 1989).

***Emotional well-being.*** Counselors should make sure teachers are sensitive to homeless children's well-being at all times. Teachers should be aware of the physical as well as emotional risk factors associated with homelessness. They should make such accommodations as the following, which include simple modifications within the classroom that can promote homeless children's social and emotional well-being. For example, to eliminate embarrassing situations, teachers should make other arrangements if children celebrate their birthdays by bringing treats (Indiana Department of Education, 1988). For another example, social growth can be facilitated by establishing a buddy system for homeless children (with the teacher stating that the child is new in the school and then praising peers for making the child feel comfortable) (Gonzalez, 1990). Other interventions teachers can implement that may help a homeless child socially include

- emphasizing classroom survival skills such as listening, asking for help, and following classroom rules (Indiana Department of Education, 1988);
- employing social skills training with the entire class from simple skills (saying please and thank you) to more complex skills (inappropriate comments) (Indiana Department of Education, 1988); and
- relieving anxiety through having a supportive, noncompetitive classroom.

Above all, teachers with students who are homeless should make school a safe place where the children can learn and see hope for their futures.

***Educating other students.*** All students should be educated on factors related to homelessness. When they learn about facets of homelessness, other students may become more compassionate to children who are in a homeless situation. Hopefully, this process will aid in the successful social integration of homeless students into our schools.

HomeBase, a project in San Francisco, has developed a packet that includes classroom activities a teacher can use to introduce homelessness, to look at the causes and effects of homelessness, and to explore taking action on homelessness. The lesson plans are detailed and varied for age appropriateness (grades K–3, 4–8, and 9–12). In the K–3 lesson on introducing students to homelessness, for example, students are asked to discuss the importance of homes (see Figure 1). As illustrated in Figure 2, students then use a picture of a house to answer open-ended questions on, for example, what they like to do in their home, why their home is important to them, and what people do in their homes (see HomeBase, 1993). Figure 3 outlines classroom activities for each level and gives topical, material, and planning information. We believe that this packet could be an excellent resource for any school. Teachers could use this packet as a base from which to make their own unique lesson plans in similar formats.

## Principals

Principals also need to get involved with homeless children's education when the children initially arrive at school, while they are enrolled, and when they leave. Upon arrival to a new school, children should be met and closely monitored by the principal (Gonzalez, 1990). This may help a child feel welcome and important. Once children are attending school, counselors and principals should establish immediate academic assessments of homeless children, particularly if they have been out of school for a period of time (Indiana Department of Education, 1988). Medical, counseling, and nutritional consultations for these children should be arranged through the school system. Schools could also be opened earlier and closed later to serve homeless children food and give them adequate shelter (most shelters make families leave before school begins and do not open until late evening) (Eddowes & Hranitz, 1989).

When homeless children are leaving school, the principal should give them a transfer card and possibly contact the next school the child will be attending (Indiana Department of Education, 1988). Making this transition smooth for children helps ensure that they feel welcome and that parents do not have to worry about obtaining appropriate documentation.

**Figure 1** | **Sample Lesson for Elementary Students on Homelessness**

### Introduction to Homelessness

**Level:** K-3

**Topic:** The Importance of a Home

**Materials:** Drawing/painting materials, magazines/newspapers, "My Home" drawing

**Time:** 2 periods

**Suggested Activity:**

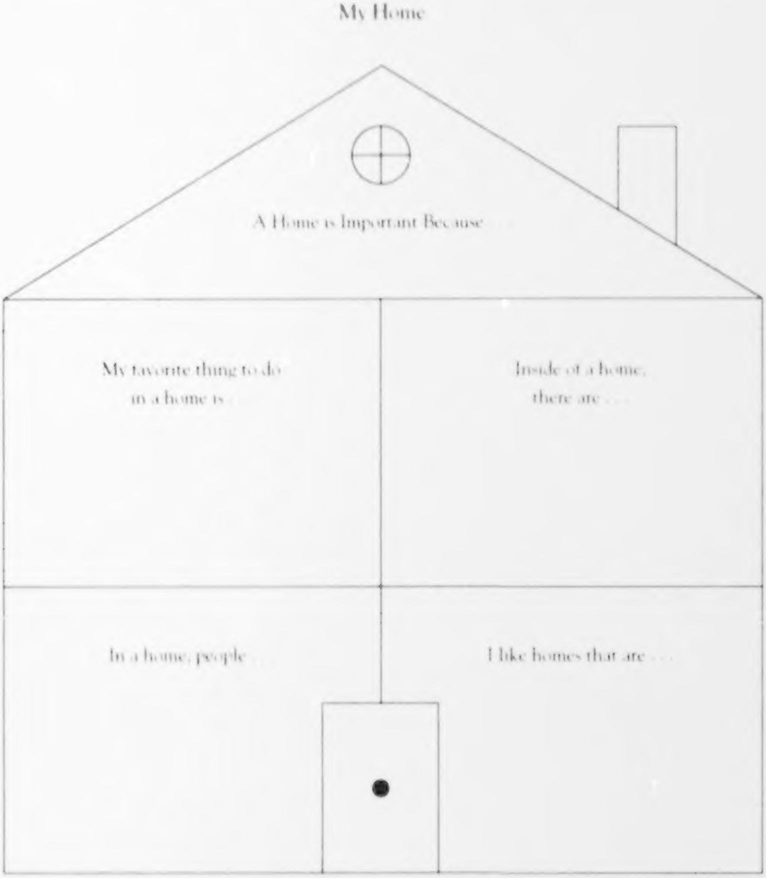
Part 1: Have students draw/paint a picture of, make a collage of, or "build" a house.
Part 2: Have students complete the "My Home" drawing individually or as a group.

**Discussion:**

- What is in a home?
- Who lives in a home?
- How many people live in a home?
- What types of homes are there besides a house?
- Where do you find a home?
- What do you do in a home?
- How do you get a home?

Source: From Homebase (1993). Reacting and teaching children without housing: Improving educational opportunities for homeless children and youth. Center for Common Concerns. San Franciso: Author by permission from the Center for Common Concerns.

**Figure 2 | Sample Activity for Elementary Students on Homelessness**


My Home
A Home is Important Because . . .
My favorite thing to do in a home is . . .
Inside of a home, there are . . .
In a home, people . . .
I like homes that are . . .

Source: From Homebase (1993). Reacting and teaching children without housing: Improving education opportunities for homeless children and youth. Center for Common Concerns. San Francisco: Author by permission from the Center for Common Concerns.

## Community Outreach

Counselors, teachers, and principals are busy with the demands of school, which already extend beyond an 8-hour school day. Asking them to become advocates for homeless children may appear beyond their call of duty. However, there are successful outreach strategies that can help them in fulfilling these responsibilities and that can be coordinated by the school counselor. Counselors should

**Figure 3 | Classroom Activities Outline**

| **Elementary School** | **Level** | **Topic** | **Materials** | **Time** |
|---|---|---|---|---|
| Introduction to Homelessness | K-3 | The Importance of a Home | Drawing/painting materials, magazines/newspapers, "My Home" drawing | 2 periods |
| Causes of Homelessness | K-3 | Losing a Home | "Oakland" story | 1 period |
| Effects of Homelessness | K-3 | What Happens to Someone When They Don't Have a Home | "If I Didn't Have a Home . . ." exercise | 1 period |
| Taking Action on Homelessness | K-3 | Doing Something to Help | Paper, pens, envelopes, or drawing materials | 1 period |
| **Middle School** | **Level** | **Topic** | **Materials** | **Time** |
| Introduction to Homelessness | 4-8 | Stereotypes About Homelessness | Drawing materials, "People Without Homes" | 1 period |
| Causes of Homelessness | K-3 | Living in San Francisco | Budgeting worksheet, classified ads | 2 periods |
| Effects of Homelessness | K-3 | Life Without a Home | San Francisco Examiner article | 1 period |
| Taking Action on Homelessness | K-3 | Making a Difference | Varying | 1 period |
| **High School** | **Level** | **Topic** | **Materials** | **Time** |
| Introduction to Homelessness | 9-12 | Stereotypes About People Without Homes | "How Homelessness Happens," "Homelessness Outline" | 1 period |
| Causes of Homelessness | 9-12 | Living in the Bay Area | Budgeting worksheets, classified ads | 2 periods |
| Effects of Homelessness | 9-12 | How Homelessness Changes Your Life | "Daily Log," "Shelter Rules and Regulations" | 1 period |
| Taking Action on Homelessness | 9-12 | Thinking About Change | Varying | 1 period |

Source: From Homebase (1993). Reacting and teaching children without housing: Improving educational opportunities for homeless children and youth. Center for Common Concerns. San Francisco: Author by permission from the Center for Common Concerns.

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begin by setting up networks with local shelters and emergency housing facilities. This will allow counselors and/or teachers to visit shelters on a monthly basis to meet with homeless families and keep them informed about their children's progress. Principals and administrators could appoint a person to be the educational coordinator between the schools and shelters. This person might be a volunteer from the community because it is important that the community also take responsibility for this serious societal problem.

Identification of homeless students who need help getting to school is a first step in terms of outreach. Community advocates are needed to help identify homeless students who are not currently receiving an education (HomeBase, 1993). This could be done through posting flyers in hotels/motels and in other places people without homes may be living (e.g., bus depots, drop-in centers, bridges) (HomeBase, 1993). Outreach to those students who have not accessed educational services is critical. It is also important to have continuous lines of communication open with local homeless shelters and churches who house students currently in school. Volunteers should be recruited to get homeless parents involved and interested in their children's education. Community help is critical for ensuring that the lines of communication remain open among schools, parents, and shelters (Eddowes & Hranitz, 1989).

Communities need to be aware of the prevalence of homelessness and the need for volunteers to help homeless families. Counselors can be key agents in initiating community assistance, which may be provided in various forms. For example, communities could help make sure that these children have transportation to and from school (Gonzalez, 1990). Schools should collaborate with day care centers to establish free care before and after school and transportation (Gonzalez, 1990). Parents who live near a homeless shelter could be responsible for taking the children to school. This could also provide good opportunities for social interactions with other children if they were transported in a group.

Parents in the community could be assigned a homeless child for whom they could provide, for example, birthday treats, school supplies, or clothing (Gonzalez, 1990). If the child moves but is in the same area, the family that originally sponsored the homeless child should remain the same, thus providing valuable continuity. People could be encouraged to interact with homeless youth prior to or following school or to volunteer time to tutor or assist them once or twice a week (Gonzalez, 1990).

State residency laws cannot be used to ban homeless children from schools. The Stewart B. Mckinney Homeless Assistance Act of 1986 stated that homeless children are entitled to free, appropriate education (National Coalition for the Homeless, 1990). However, there are no laws requiring in-depth identification of these children so that they can be educated in the schools based on their unique needs. Thus it is up to communities and, more specifically, to shelters and social services to work together as a coalition to protect the right of homeless children to a free and appropriate education.

## ADAPTATION FOR DIVERSITY

Unfortunately, many homeless youth are faced with other needs that require adaptations in addition to those already described. Given that impoverished children are at increased risk for academic and emotional problems (Lewis & Doorlag, 1987), we can assume that homeless youth are equally at risk for similar problems. Thus screening of homeless youth at a young age for both behavioral and academic problems becomes a necessity. It is also important for teachers to recognize what learning and behavior problems may be the result of homelessness. For example, a student who is homeless may display classic symptoms of hyperactivity (e.g., difficulty attending to tasks), but it may be because this student is preoccupied with his or her family's difficulties and more pressing problems and is not focused on the teacher's lecture or a class activity.

If a student is having a problem learning in school due to environmental circumstances, the least intrusive intervention is to personalize the learning process (Adelman & Taylor, 1993). Students who are homeless may need to have high expectations of success and a value for learning prior to engaging themselves in their school work. Students who are homeless may always be asking "Is it worth it?" when deciding whether they will participate in school. All students, and particularly those in extreme adverse conditions, should have a personalized program in school. Programs should match students' developmental levels with their motivational levels to create an optimal environment for engaged learning.

## SUMMARY

Homeless children suffer physically, psychologically, socially, and academically. It is appalling that almost half of homeless children are not being served. A portion of this population could be readily identified through homeless shelters and other social agencies. The first sections of this chapter addressed the demographics and characteristics of these youth. Given a problem of this magnitude, who will advocate appropriate education for homeless children? Unfortunately, the parents of homeless children are not usually lobbying for laws or taking schools to court. Homeless families may not be aware of their educational rights or may feel powerless to change the status quo. Thus not only must there be provisions for homeless children in the classroom, but also their parents must be informed and involved. Counselors, teachers, administrators, and communities need to take the initiative both for passing laws and for educating parents and individuals about their rights.

Research including homeless children is scarce despite the large numbers of homeless children in the United States. More information regarding homeless children and the barriers they face within and outside of the school system is needed. Similarly, future research should reveal successful classroom models that meet the needs of homeless children. Additionally, the prevalence of homelessness and homeless children's needs must be recognized by all state departments of education. Once educational departments have a clear picture of homelessness in their state, they should apply for federal grants to fund interventions.

If we do not identify and intervene with homeless children, thousands of children will grow up uneducated and bitter. How can we expect homeless children to be involved in a society they do not understand or respect? How can the children find empowerment and break the cycle of homelessness if no program has identified them and/or provided opportunities? It is unconscionable that homeless youth even exist in this country. Our society is destined for even greater tragedy if the educational rights and opportunities for homeless children are not mandated and vigorously upheld. As this chapter suggests, collaborative efforts among families, schools, and communities that are coordinated by school counselors can be effective strategies for ensuring and providing essential education opportunities for homeless youth.

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# 15 Understanding and Preventing School Dropout

*James W. Kushman and Paula Heariold-Kinney*

School dropout is a highly visible sign of a society that has failed to prepare its youth for successful transition into adulthood. It is an issue that should be of great concern to school and community counselors working with young people and their families. School dropout is a problem that has recently gained much public attention. Ironically, the heightened concern about students not completing school comes at a time when long-term demographic trends show a decline in the high school dropout rate. Recent census data reported by the National Center for Education Statistics (McMillen, Kaufman, Hausken, & Bradby, 1993) indicate that high school noncompletion rates among 16- to 24-year-olds have declined since the early 1970s from approximately 14.5% to 11% in the general population. Yet, this 11% dropout rate in 1992 translates to about 3.4 million youth who risk unproductive lives because they have not completed high school and are, therefore, unprepared for 21st century jobs. Although the declining census statistics may give us some comfort, state-level statistics show a rather different trend with high school noncompletion rates creeping upward between the early 1970s and the late 1980's (Rumberger, 1987). In the early 1990s, achieving a high school completion rate of at least 90% became one of the National Education Goals. A 1993 National Education Goals Report, however, indicates that the high school completion rate has yet to change much since the 1980s. High school dropout continues to be a matter of great concern because of its negative impact on the social and economic health of the country (Asche, 1993).

Note that estimates of the dropout rate can vary to a surprising degree depending on how *dropout* is defined and measured. Sources of dropout statistics include special U.S. census surveys, large national samples of youth who are tracked over time such as the High School and Beyond data, and data compiled by state departments of education and local school districts. As yet, there is no consistent, agreed-upon method for measuring school dropout. Caution needs to be exercised in comparing dropout rates from different data sources.

It is clear that the dropout problem does not affect all groups equally. Poor and minority students tend to experience the highest dropout rates, and males show higher rates than females. Figures from the U.S. Department of Education's High School and Beyond national sample of 1980 high school sophomores indicate that 19% of Hispanics and 17% of Blacks drop out of school by their senior year, compared to 13% of Whites. Dropout rates by socioeconomic status (defined by family income and parents' occupation and educational background) show the top half of the social stratum with a dropout rate of 18% compared to a rate of 35% for low and low-middle socioeconomic students (High School and Beyond figures as reported by U.S. General Accounting Office [GAO], 1986). Given these disparities, it is not at all surprising that the dropout problem is most concentrated in large urban areas where poor and minority students tend to live. It is not uncommon for more than half of the students to drop out in some inner-city high schools. However, the stereotype of the inner-city minority youth dropout is not always the case. About 75% of school dropouts are White, and 62% live in the suburbs, according to National Center for Education Statistics data (NCES, 1989).

There are both moral and economic implications of students dropping out of school. First, a society based on humanistic and democratic ideals cannot simply sacrifice or write off large numbers of youth who, because of their failure in school, gravely limit their potential and future well-being. Second, there are serious economic consequences of an undereducated population. Large numbers of dropouts weaken the economy because they are unprepared to work and because they place a burden on unemployment and welfare services, not to mention the criminal justice system. Dropouts run the risk of becoming drains on society rather than productive and contributing members. Census and labor market surveys indicate that today's high school dropouts are two to three times more likely to be unemployed than high school graduates and are also more likely to find themselves in low level jobs (GAO, 1986). The problem is exacerbated as we move further into a postindustrial economy where important jobs will require more education and more problem-solving and thinking skills. Coupled with the changing nature of work is the fact that ethnic groups with high dropout rates, such as Hispanics, will continue to compose a greater share of the work force. In addition to the relationship between dropping out and employment, high school dropouts are also more likely to engage in other high-risk behaviors such as premature sexual activity, early pregnancy, crime and delinquency, alcohol and drug abuse, and attempts at suicide (Asche, 1993).

That young people do not complete school is both a moral and an economic tragedy. In a general sense, counselors can play an important role by helping at-risk youth realize the tragedies that may lie ahead. Counselors must help at-risk youth see the connections between present choices to stay in or drop out of school and future personal consequences such as wasted lives, unemployment, and involvement in crime. This does not require moralizing, but rather providing young people with a realistic picture of the consequences of not completing their education. Interestingly, youth who drop out of school tend to experience increased self-esteem at first, but over time, these feelings tend to be replaced by great remorse as negative personal consequences are fully realized.

Although the label *dropout* is conveniently applied to large numbers of students who do not finish school, such a label belies the fact that they are a diverse group who leave school under diverse circumstances. The implication is that there is no single cure-all that can be uniformly applied by counselors or educators. Helping potential dropouts requires a clear understanding that the problem is complex and multifaceted. Bickel, Bond, and LeMahieu (1988) pointed out that the term *dropout* itself is potentially misleading because it implies an event instead of a process, that is, a single decision point to leave school, with the student as the sole decision maker. Such is far from the reality. Some students merely fade out after a period of feeling alienated from school. Others can be subtly or not so subtly pushed out by school personnel who do not want to deal with them any longer. Still others are pulled out either by more important demands on their time such as parenting or having to work, or by negative community influences such as gangs. It is also important to remember that some students leave school but do return, perhaps only to drop out again. As yet, a precise typology of early school leavers has not been developed. Orr (1987) has proposed a four-part typology that begins to distinguish between qualitatively different types of students who are at varying risk of dropping out: (1) students experiencing some problems in school with a marginal risk of dropping out; (2) those interested in staying in school but who cannot because of personal circumstances such as parenthood or the need to work; (3) students at great risk of dropping out as evidenced by poor attendance, lack of interest, and low grades; and (4) those who have left school and are in need of special services to complete their education and become better prepared for work. This is a start to understanding the complexity of the problem and the diversity of the students whom we conveniently call *dropouts*. It is clear that different students leave school under different circumstances and for varied reasons, even students within the same school. In this chapter, we unravel some of the complexity of the dropout problem, and we will talk throughout about the student, the family, the school, and the community as four points of intervention. We also discuss two broad strategies of intervention: the *clinical approach*, which focuses on the individual, and the *systemic approach*, which focuses on the larger system in which the individual functions.

## PROBLEM DEFINITION

A great deal of research over the years has attempted to identify factors related to school dropout. Rumberger (1987), in his review, classified the many variables into six categories: demographic, family-related, peer influence, school-related, economic, and individual. Perhaps a more useful distinction for designing counseling interventions is to think of variables as falling into two broad categories: *demographic correlates*, which represent the students' more stable background, and *early warning signs*, which represent more immediate and alterable student characteristics.

## Demographic Correlates

It has been well documented by now that some racial minorities—Native Americans, Hispanics, and African Americans—are more likely to drop out than Whites, and that males are more likely to drop out than females. Race seems to be important, but what factors underlie racial differences? Rumberger (1983), using data from the 1979 National Longitudinal Survey of Youth, found that when background and home characteristics such as parents' education and aspirations, income level, and number of reading materials in the home are held constant, the racial gap in dropout rates virtually disappears. Similarly, more recent data from the National Center for Educational Statistics indicate fewer racial differences when we look within family income levels. African American and White dropout rates are virtually the same when income level is held constant, but Hispanic dropout rates are higher than those of African Americans or Whites at the low and middle income levels. Thus, although dropout rates are higher among minorities of color, these differences seem to be more a result of poverty and social class than race. For Hispanic and other immigrant students who may have limited English-speaking capabilities, language is also a factor. Among Hispanics who speak English well, the dropout rate is 17% compared to a dropout rate of 83% for Hispanics who speak no English at all (McMillen et al., 1993).

A cultural-differences argument also has been made to explain why some minority groups fail in school. This view has been most clearly articulated for African American students. Ogbu (1981, 1986) and Boynkin (1986) hypothesized a deep-seated cultural conflict between the Black experience in the American urban ghetto and in public schools. The cultural conflict centers around two issues: (1) the devaluation of mainstream education by Black culture and families given the few perceived economic benefits of completing a formal education, and (2) differences between the culturally rooted thinking and behavior styles of African American children and schools that cater to a Euro-American style of behavior and learning. This second point is rather controversial—that is, whether unique ethnic styles of learning and cognition actually exist. Shade (1982) reviewed the literature on African American cognitive styles, and although some studies have found specific differences between Blacks and Whites, the evidence is sparse and far from conclusive.

Thus social, ethnic, and cultural background are the major demographic correlates of school dropout. Students who have traditionally not been part of the American mainstream, such as the poor and people of color, may experience greater difficulties in school. Schools are not always responsive to the needs of different ethnic and cultural groups. Although we do not yet fully understand why some groups drop out more than others, it seems clear that such differences are best understood in terms of underlying factors such as poverty, family circumstances, language skills, and cultural differences to which schools have been slow to respond. We live in an increasingly pluralistic society. Counselors working with at-risk youth need to be sensitive to the diversity of backgrounds and cultures from which today's students come. Adaptations to diversity are discussed later in this chapter.

## Early Warning Signs

The factors just described represent relatively stable and unchangeable background characteristics of the individual. Another set of variables are characteristics and circumstances that are more immediate and alterable through educational and counseling strategies. Studies have identified a variety of school and personal factors predictive of dropping out, factors that counselors can view as early warning signs. These variables fall into four categories: poor academic performance, behavior problems, affective characteristics, and personal circumstances.

Poor academic performance is usually evidenced by low grades, low test scores, and being held back one or more grades before high school. School counselors do need to communicate with teachers so that patterns of low performance or academic failure can be identified early. Academic performance is intertwined with behavior and affective problems, with which counselors deal directly. Behavior problems are usually evidenced by disruptive classroom behavior, cutting classes, truancy, and suspension. The affective areas that counselors are most likely to have to treat are poor or unrealistic self-concepts and feelings of alienation—that is, feelings of not fitting into the school or classroom. Many student circumstances such as teen pregnancy, teen parenting, having to work, and caring for sick or elderly family members can also conflict with school demands. This is an area where counselors can play a critical role in helping students find ways to balance school and outside demands, and in advocating for students who have unique circumstances that require special school or community services such as a teen mother program.

Obviously, some of these factors can occur early in a student's school career, and the question of when to identify potential dropouts is a crucial one. As in other counseling areas, early identification is a delicate matter not to be taken lightly. Although it is desirable from a prevention standpoint to identify potential dropouts as early as possible, caution must be exercised. It is imperative to avoid harsh labels that lead to stereotyping by teachers and other students, and to negative self-concepts and lowered aspirations among those so labeled.

How early can potential dropouts be identified? Certainly earlier than high school and even as early as the primary grades. A study by Lloyd (1978) of a group of 1,500 students was able to discriminate school dropouts from high school graduates successfully based on third-grade and sixth-grade student characteristics. For the third-grade analysis, a combination of four factors was found to discriminate dropouts from graduates with 75% accuracy: (1) achievement scores (especially in reading), (2) global ability (IQ test), (3) socioeconomic status and family background characteristics, and (4) retention (nonpromotion) during the first three grades. The same characteristics were found to hold for the sixth-grade analysis, with the addition of school attendance. Although such variables are predictive of dropping out, it is important to keep in mind that they are not foolproof indicators. In Lloyd's discriminant analysis, for example, one quarter of the students were misclassified based on third-grade characteristics, pointing out that some students do succeed despite early warning signs to the contrary. And of course success is much more likely when prevention and early intervention measures are taken by counselors and other school staff.

Although identifying individual student risk factors is important to planning and implementing counseling interventions, we do not wish to advocate a blaming-the-victim mentality that such an exercise often becomes—that is, focusing all of the blame on students and their behaviors. One point of view, developed later in this chapter, holds that schools and other institutions must take their share of the responsibility for the dropout problem. Relevant to this argument is an educational issue currently being debated. Educators are beginning to wonder whether new school reforms aimed at raising academic standards are at least partially responsible for increases in school dropout. McDill, Natriello, and Pallas (1987) identified three possible ways in which this might happen. First, a high school curriculum that is narrowly focused on basic skills instruction not only limits student choice but also defines student success in narrow terms. These conditions have the potential to push low performing students out, especially those who enter high school with a long history of academic problems.

A second school reform that might have an adverse effect is increased learning time outside of the school (e.g., assigning more homework, an extended school day). Although time is not a scarce resource for many teenagers, some have legitimate adult demands on their free time such as working to supplement family income, helping with sick relatives, or raising children. Without some concessions for these students, increased academic time demands can become another reason for leaving school. A further complication is that afterschool academic time usually takes away from extracurricular activities, activities that may be the only positive attachment to school for students who experience problems in the classroom. With regard to homework, students who live in overcrowded households or have undereducated parents may lack adequate support outside of school to meet increased homework demands. The third school reform, tougher graduation standards and minimum competency testing (the practice of not graduating students until they demonstrate minimum basic skills in reading, math, and language), also can have obvious adverse effects on students with academic difficulties. If standards are raised, additional assistance is needed for students who cannot easily meet the tougher graduation criteria.

Speculation continues about how recent school reforms might adversely affect at-risk students, but there has been no research to confirm or deny these suspicions directly. Nevertheless, it is certainly reasonable to assume that rigid school reforms that fail to take into account the needs of at-risk youth may do more harm than good.

## Underlying Causes

Up to now we have described the important correlates of dropping out, but this is far from a deep understanding of the complex and underlying causes of dropout behavior. Two studies with a more explanatory focus are described here, with special attention paid to presumed causal factors that are most relevant to planning counseling strategies.

In the first study, Ekstrom, Goertz, Pollack, and Rock (1986) looked at differences between school stayers and leavers and tried to answer the question of why one student drops out and not another. The study analyzed data from the High School and Beyond national sample of 30,000 high school sophomores and seniors. Behavior and attitude measures were taken of sophomores in 1980 and 2 years later for both graduates and nongraduates. Consistent with research on smaller student samples, the study found that behavior problems and low grades were the major differences between these who graduated and those who did not.

The behavior pattern of the sophomores who eventually dropped out showed less affiliation and more disengagement from school than among those who graduated. Specific behaviors of the dropout group included doing less homework (an average of $2\frac{1}{4}$ hours per week for dropouts vs. $3\frac{1}{2}$ hours for graduates), participating less in extracurricular activities such as athletics, and more frequently working for pay during their sophomore year, although here the difference between dropouts and graduates was small. An important attitudinal difference regarding work, however, was that dropouts were more likely than graduates to view their current jobs as being more important than school (23% vs. 10%). Other attitudes of dropouts matched their disengaged behaviors. Dropouts expressed more alienation from school life and were less interested and less satisfied with school, their teachers, and their education generally. Dropouts also felt less popular than graduates. An interesting finding was that dropouts tended to have friends who expressed the same feelings of alienation, which suggests the importance of peers in influencing the attitudes and behaviors of at-risk students.

The study by Ekstrom, Goertz, Pollack, and Rock (1986) also tested a causal model using a statistical procedure called *path analysis*. This model provided evidence that parents and home life play a large role in dropout behavior. It found that whereas disciplinary problems and low academic performance had the most immediate effect on decisions to stay in or drop out, a lack of family involvement was seemingly an important cause of the school misbehavior and academic problems. Lack of family involvement was evidenced by few educational supports in the home (e.g., reading materials) and parents who were uninvolved in helping students make curriculum choices. The model further found that dropouts were less likely than graduates to discuss their school experiences with parents.

In the second study, Wehlage and Rutter (1986) also analyzed the High School and Beyond sophomore data. Using a statistical technique called *discriminant analysis*, selected variables were used to predict membership in three groups: those who had dropped out by their senior year, those who stayed in, and those who were college-bound. Although the first set of variables reflected traditional findings such as low socioeconomic status, low student expectations, and low academic performance as predictors of dropping out, a second set of variables was also found to be important independently of this first set. The second set of variables showed negative school experiences (most notably, discipline problems) and life style factors like truancy and increased hours spent working outside of school as circumstances that discriminate dropouts from graduates and college-bound students. The authors interpreted these and other findings as suggestive of a dropout process in which, for some students, the school experience is negative and leads to disengagement, alienation, and loss of commitment to the goals of graduating and continuing with education. For these students, schools lack holding power.

In both studies, the presumed causes of school dropout involved a set of related variables that cut across the student's experiences and behaviors, the school environment, and support systems outside of the school including parents, peers, and community agencies. Thus there are multiple points where counselors and others must intervene, including the following:

1. *Student behaviors within the school*
    - poor academic performance;
    - cutting classes; and
    - noninvolvement in school life outside of the classroom.
2. *Student behavior outside of school*
    - truancy;
    - increased hours spent working or in illegal activities; and
    - drug and alcohol use.
3. *Student affect*
    - feelings of hopelessness;
    - not feeling in control of life events; and
    - lowered self-esteem.
4. *Student life circumstances*
    - teen pregnancy or parenting; and
    - social and economic hardships that place adult demands on young people.

5. *School climate*
    - quality of teacher-student interactions;
    - effective but fair school discipline procedures; and
    - accommodations to students who must combine school with work or family responsibilities.
6. *Home and family*
    - parental interest and involvement in the student's school experiences and progress; and
    - identification of abusive parents.
7. *Community*
    - negative peer influences that can accelerate student disengagement; and
    - community support programs (e.g., teen mother services) through counseling agencies, churches, and volunteer groups.

Several larger themes overlay the many variables and points of intervention. The first is opportunity to learn. At-risk students may require more opportunity to learn (that is, more time allowed for learning tasks), given their poor academic performance. Unfortunately, time is a limited resource for some at-risk youth who have legitimate adult responsibilities outside of school such as teen parenting or working.

A second theme is motivation. Simply having students spend more time in learning tasks will not suffice if they are not motivated to learn. At-risk youth must believe that they can succeed in school and must perceive some present and future value for their hard work if they are to become motivated. They must see a positive future and job opportunities beyond high school.

A third theme, related to motivation, is commitment. Commitment can be viewed as the opposite of alienation, a condition that characterizes many dropouts and their teachers. In order for students to feel committed to school, they need teachers and counselors who are themselves committed to their students and school, and they need to feel involved in school life outside of the classroom.

The last theme is empowerment. Empowering students with some legitimate responsibilities (e.g., a say in discipline policies, curriculum choices) should lead to increased identification and affiliation with school. Empowering teachers and counselors with the responsibility and decision-making power they need to help students is likewise important.

## CASE STUDIES

The research findings are perhaps best illustrated through case studies, which provide a richer, up-close look at school dropout and its causes. Two case studies are presented here, one on a school, the other on an individual student. This is in keeping with the chapter's dual focus on both the individual dynamics of dropout and understanding how the system contributes to students' decisions about whether to stay or leave.

## The Story of a School in Harlem

An in-depth case study of a comprehensive high school in upper Manhattan conducted by Michelle Fine (1986) provides an excellent illustration of how a variety of school factors can contribute to school dropout in the inner city. The school, composed of low-income students who were primarily African American and Hispanic, was in a poor area of the city, but characterized as having a good reputation for safety and stability. To identify some of the basic school structural characteristics that may lead to dropout, Fine conducted observations in classrooms and other school settings, looked at student autobiographies, conducted in-home interviews with 30 recent dropouts and 15 who had dropped out 4 years earlier, and administered surveys to 350 ninth graders, some of whom were followed up later. Her results revealed that different students express different reasons for dropping out. Some of the students were very critical of schooling and its worth in obtaining a job or a good income. Others had to attend to family health or economic needs that interfered with school. Still others simply felt a sense of hopelessness in the midst of poverty and their own school failure. Another group felt pushed or thrown out by school personnel who did not want to deal with them any more. There was no single self-reported reason, even within the same school and urban environment.

Fine (1986) described the subject of her case study as a school that had a disproportionate share of low-achieving students, insufficient resources, and overcrowded classrooms. Teachers and administrators in this school were predominantly White, and students were predominantly African American and Hispanic, which led to poor communication and a lack of understanding between teachers and students. Classrooms, Fine reported,

> . . . are organized more around control than conversation, more around the authority of the teacher than autonomy of students, and more around competition than collaboration. When students talk to each other or cooperate it often provokes accusations of cheating from their teachers. (p. 403)

Fine (1986) used the term *disempowerment* to explain the process of dropping out. Many teachers reported a sense of disempowerment, felt that no one listened to them, felt that school policy did not reflect what was really important for students, and believed that students could not be helped. Teacher feelings of disempowerment carried over to students, many of whom in turn developed feelings of powerlessness and alienation, and eventually dropped out.

The disempowerment hypothesis is consistent with the research findings on the psychological state of dropouts both before and after they leave school. Two important variables here are locus of control and self-esteem, variables investigated in the two studies using the national student database discussed in the preceding section. Both High School and Beyond studies (Ekstrom et al., 1986; Wehlage & Rutter, 1986) found that dropouts projected a more external locus of control than did graduates; that is, they had feelings of having little personal control over what was happening to them. This was especially true among African American dropouts. Both studies also found that the level of self-esteem among dropouts (measured by items such as "I am as able to do things as well as other people") improved once they left school. Although this may seem surprising at first, leaving a situation that has become a source of many negative experiences is sure to be accompanied by feelings of relief and even heightened self-esteem as new possibilities are in sight.

Similarly, Fine's (1986) study of the inner-city high school also found that most students who left school were highly energized and motivated at first. Among the 30 dropouts she interviewed 4 months after they left school, 28 were engaged in legal and productive activities like enrolling in GED programs, applying to trade schools, or working in low-level jobs, although some also reported illegal activities like drug dealing. Seven of 15 students who had dropped out of the school 4 years earlier were also interviewed, and things were generally not going well for them. Fine (1986) concluded that although there may be some initial psychological advantage to leaving school, this advantage is soon lost as negative consequences begin to accumulate.

The study of this school in Harlem illustrated at least two ways high schools contribute to school dropout. One is that because students experience high school in many different ways, some students may see no value in completing high school and little connection between what goes on in school and their present and future lives. Others may have personal circumstances that prevent them from fully participating in school while still others may be pushed out because of behavior problems or because they do not fit in. Yet others may experience a cultural alienation because their language and culture are not reflected in the adults who run the school. Until schools are able to address diverse student experiences and needs, they will continue to lose too many students.

A second way that large high schools can contribute to dropout is that they are often bureaucratic places for both students and staff. This leads to a sense of powerlessness and futility. Teachers and counselors feel that they can do little to help students, and students sense that the staff is uncaring. An unproductive cycle of hopelessness and blame can result, and students drop out. However, this cycle can be broken, and schools can become a more meaningful learning experience for students, by empowering both students and staff on issues like creating fair discipline policies, making curriculum and instruction more engaging and related to the real world, improving school climate, and changing school scheduling.

## The Story of a Disaffected Student in Portland

Shamica is a 15-year-old freshman attending a comprehensive high school in Portland, Oregon. She entered high school with reading and math achievement scores below the ninth-grade level. Shamica has no stable or supportive family structure, and she has not had one for much of her life. Her mother deserted her when she was in the sixth grade, and she has lived in several foster homes since then. She is currently living with her sister's 24-year-old friend and her live-in boyfriend. Shamica is a heavy-set girl who looks older than her 15 years. She is very loud and boisterous in classes, and was suspended from school the second week into the semester and several times since for attendance, tardiness, and behavior problems. Currently, she awaits an alternative placement because she will not earn enough credits to complete her ninth-grade year.

When talking about school, her teachers, and her living situation, Shamica expresses a sense of hopelessness, bewilderment, and rejection. Here is one of her typical statements about school:

> My teachers don't care about me anyway! Whenever I try to do right, they are still in my face. Even when I put my hand up, they don't call on me. So when I yell out the answer, they tell me to put my hand up first. I don't even care.

When referring to her living situation, she responds with some sadness. Her body language becomes that of a much younger girl, and her voice grows quiet. She describes her living situation in the following way:

> I have lived all over the place. Every time I move, I lose more clothes because my foster parents take them. Even though I don't like where I live, at least I have my own bedroom. But every time they get mad at me, they tell me that they are going to throw me out. I try to stay out of their way or stay in my room when I am home. When I get married, I'm not ever going to let anything happen to my kids.

Shamica is a living example of the statistical evidence discussed in the study by Ekstrom, Goertz, Pollack, and Rock (1986) and of more recent statistical evidence showing the importance of family support in keeping young people in school (Horn, 1992). She illustrates how parents and home life can influence dropout behavior. Shamica's low self-esteem, her acting out, and her low grades can be seen as attempts to get attention, even if in a negative way. Her lack of a stable family structure, which if present could ease her feelings of isolation and hopelessness, seems to play a significant role in Shamica's inability to succeed in school. She also demonstrates in her comments a sense that the school and her teachers have given up on her, and she seems to have no place to turn in order to solve her problems.

## APPROACHES TO PREVENTION

Much research has been done to identify the impediments to students who are at risk of dropping out. The question now becomes what to do about students once they are identified as possessing these characteristics. Counselors and school administrators are continually searching for new approaches that will enable them to implement effective strategies that may prevent students from leaving school. Generally, there are two types of approaches that can be employed: the clinical approach and the systemic approach. The clinical approach focuses more on direct student and family interventions; the systemic approach is concerned with how the school and community must respond to at-risk students.

### Clinical Approach: Treating the Student and Family

The clinical approach is probably the more common and more familiar to counselors because it deals directly with the student and his or her family. This approach asks the question, "What's wrong with the student?" It begins to look at predictors and indicators intrinsic to the student who risks dropping out of school. In most cases, this approach addresses questions in three areas:

1. *The home*
   - Does the student come from a low-income family, a poorly educated family, or a family with serious financial problems?
   - Does the student come from a dysfunctional family where there is dissension, alcohol, or drugs?
   - Were the parents or are the siblings dropouts?
   - Is the student emotionally or physically neglected or abused in the home?
2. *Personal traits or circumstances*
   - Does the student have low self-esteem?
   - Does the student lack motivation?
   - Does the student exhibit boredom?
   - Is the student pregnant?
   - Is the student addicted to drugs or alcohol?
3. *School behaviors*
   - Is the student frequently absent?
   - Is there a lack of interest in school work?
   - Does the student exhibit hostility, unruliness, passivity, or apathy?
   - Has the student repeated grades?
   - Does the student have difficulty with reading, math, and communication skills (especially in the early grades)?

The astute counselor must zero in on these factors and begin to develop a planned, coordinated response of prevention and treatment. Among educational and counseling strategies that have been tried over the years to address the problems of students who are at risk of dropping out are special education, remediation, and alternative programs.

*Special education* has been an approach for the student whose behavior and poor academic performance indicate that he or she needs something educationally different than the regular program. Special education may have saved some students from dropping out of school because of individualized instruction and small class size. However, for other special education students who truly did not have a handicapping learning condition but possessed other factors that adversely affected their learning, special education may have led them to feel alienated, unworthy, and even more of a failure. Counselors should be aware that with special education students, or other special populations, work may have to be done to build self-concepts.

*Remediation* has been another method for addressing the academic problems students experience in school. Many students who are at risk of dropping out may have been retained in at least one grade. Another remedial approach is ability grouping, which places underachievers in slower classrooms so that they can catch up. The problem with ability grouping is that students in slow classrooms experience embarrassment and lowered self-esteem, and as a result, behavioral problems often begin to erupt. Research has shown that placing students who have academic or behavioral problems together in the same classroom does not improve student achievement or self-concept (Kulik & Kulik, 1982). On the contrary, ability grouping may worsen the situation because a social hierarchy is inadvertently set up in the school that negatively stigmatizes low-group students (Rosenbaum, 1980; Winn & Wilson, 1983). However, when low-ability students are mixed with average and high-ability students, negative stereotypes are avoided, and the slow students may become more challenged and improve. It is important to point out that remedial strategies can be effective if these negative consequences are foreseen and dealt with by, for example, grouping students for only part of the day and providing a lot of individualized instruction within the classroom so that low students can succeed at achievable academic goals. Students tutoring other students, or cooperative learning, is another effective strategy for students who need remediation.

One of the most successful approaches for addressing the needs of at-risk students is to place them in an alternative program, if such programs are available. *Alternative program* is a label for a variety of nontraditional elementary and high school programs that are usually housed in separate buildings away from the traditional school. There is no single model alternative program, nor do these programs always serve the same population. One type of alternative program is the special school for high-risk students who have been repeatedly suspended or otherwise do not seem to fit in at conventional schools. Alternative schools of this type employ individualized academics along with counseling services that are designed to better meet the needs of at-risk youth. Although alternative schools aim to change the student and therefore come under the clinical approach, these schools also represent the systemic approach (discussed in the next subsection) because the school and its program are structured around the needs of students. The alternative school is perhaps the best contemporary example of combining the clinical and systemic approaches.

An effective alternative program better meets the needs of most at-risk youth because of smaller school and class size and more individualized personal attention, including counseling services. Other characteristics of a successful alternative program include autonomy from the regular school, highly committed staff, nontraditional and varied curricula, experiential education involving work in community settings, and a supportive atmosphere resembling a family setting (Wehlage, 1983, 1991). Alternative programs can provide a safe, caring environment that for many at-risk youth may be the only place where they receive positive attention. For some students, the alternative school may be the only stable home or family they have.

Alternative programs have been regarded as a highly successful approach (see Institute for Educational Leadership, 1986), but the research findings on the effectiveness of such programs have been mixed, partly because of poor research methods. At-risk students tend to prefer alternative programs to regular school and feel better about themselves in a learning environment that provides more personalized student-teacher relationships (Educational Research Services, 1977). Beyond this general effect, however, we do not yet understand how different alternative interventions affect different types of at-risk youth, especially with regard to the myriad counseling interventions that an alternative school might use. Evidence shows behavior modification to be effective with students who act out, but other types of counseling modalities have undergone little systematic research (McDill et al., 1987).

One decision that counselors in both regular and alternative schools may face is whether to treat students in the school setting or outside. There can be some advantages to counseling retreats that temporarily remove students from a school environment that is unpleasant or not conducive to positive change, but isolating students from the school in order to treat them may have unintended negative effects. An interesting study by Catterall (1987) of a 4-day high school counseling retreat found no positive effects of the retreat, and even some slight negative effects when program participants were compared to nonprogram controls. The retreat involved self-concept building activities; skills training in teamwork, decision making, goal setting, and academic learning; and challenge and relaxation exercises. The study found that students who participated in the retreat perceived significantly more negative labeling by teachers and less social bonding to teachers than did controls 4 weeks after the program. One plausible explanation for these unintended effects is that retreat programs may serve to increase student isolation and alienation from the school. Such programs may reinforce student bonding to other at-risk youth and weaken ties with teachers and school.

In discussing clinical approaches, the importance of collaborative relationships between schools and social service agencies must be stressed. At-risk students, in many cases, have other problems besides experiencing failure and frustration in school, as the research reviewed earlier clearly indicated. Behavioral or psychological indicators that students exhibit in school may alert counselors to other problems in the student's life. It is important that the whole student be addressed and not only behavior within the school. In some school districts, student service centers have been implemented in order to personalize counseling and support services that are essential to address fully the needs of at-risk youth. If student services are not available via the school district, counselors and administrators should take steps to bring these services to the schools or provide transportation for students to community agencies. Support and counseling services are also important for parents of at-risk youth who may be contributing to the students' failure in school.

All the strategies described here can have positive effects on students who are experiencing failure, frustration, and unhappiness in school. However, the clinical approach in and of itself may not solve the problems of the potential school dropouts. The intention may be to help students, but some clinical interventions carry a negative stigma that can result in these programs doing as much harm as good. For example, students who are placed in slow classrooms for several consecutive years are in danger of being labeled learning disabled throughout the rest of their school career. Although school systems have begun looking more closely at mainstreaming special education students, the numbers of students who are moved into regular programs are still too few, especially for certain groups such as Black adolescents. Another concern is equity. In many instances, students who are placed in special programs, including alternative education, may receive a watered-down version of the curriculum, leaving them unprepared for postsecondary education or the working world. Expectations may be lowered for students who are enrolled in special programs, and their failure can become a self-fulfilling prophecy.

In addition, although dealing with the individual and his or her family represents an important prevention strategy, there are several limitations to the clinical approach. One is that the goal of some counseling programs is simply to help at-risk students feel good about themselves rather than improving academic performance. It is important to remember that students generally feel good about themselves if they are academically successful. A more basic limitation of the clinical approach is that it assumes the problem lies solely within the student. Efforts are geared toward fixing the student so that he or she will function better in the traditional school. Too much time and energy can be spent on trying to impact difficult-to-change factors outside of the school such as dysfunctional families and the effects of poverty. The school takes on the role of becoming a social rather than an educational agency. A more fruitful approach for treating the whole student is the systemic approach.

## Systemic Approach: Changing the School and Community

The systemic approach focuses on changing the educational system to meet the needs of at-risk students. The educational system is defined to include both the school itself and its interaction with the surrounding community. The systemic approach is more difficult to implement than the clinical approach and, therefore, is one that many school districts shy away from. High levels of commitment from the community, the school board, the superintendent, principals, staff, parents, and students are required for the systemic approach to work.

The systemic approach recognizes the unalterable or difficult-to-change factors, like poor home environments and poverty, but does not allow these factors to become an excuse or roadblock for not successfully educating all students. Unalterable factors are taken into consideration in designing a school that is responsive to the whole student and to all students. For many at-risk youth, school is a place where they feel isolated and discouraged. Because of their circumstances and backgrounds (e.g., having to work to support self or family, feeling culturally or racially isolated, possessing a learning style that does not mesh with traditional ways of teaching), school can become a place of frustration for many students. In the case of female students who become pregnant or are already teen mothers, dropping out may be the only solution if accommodations cannot be made for their educational and personal needs (e.g., class scheduling, day care, prenatal care). For most young people, the way to handle an extremely frustrating situation is to rebel and act out, or simply to leave the situation—as many students do when they drop out of school.

A progressive school district that supports the systemic approach recognizes the fact that with the diverse demographic makeup of the total student body, it is necessary to design a flexible system around the needs of students. Schools become more student-centered. Further, the community is viewed as being in partnership with the school rather than part of the problem. Factors within the school that can impede student success and serve as obstructions for at-risk students are addressed for the benefit of all including:

1. *Organizational structure.* The organizational structure of the school can be a major barrier to student success. To begin with, many urban schools are simply too large. Students who attend a large school with large class sizes tend to feel overwhelmed and defeated, especially in transition years such as the sixth and ninth grades. The at-risk student may already be skeptical as he or she enters middle school or high school. These students need to feel accepted on a personal basis and need to feel involved, which is almost impossible to accomplish in a large school. A recent synthesis of

the research base by Dryfoos (1990) pointed to the debilitating effects that large high schools can have on students.

School hours are another aspect of the organizational structure that can make it difficult for at-risk students who have to work as well as attend school. The way school hours are scheduled, usually from 8 a.m. to 3 p.m., leaves little flexibility for working students. Class scheduling can also be unrealistic. Classes are often set up for 50-minute periods in high school, during which time students are expected to digest all of one subject matter such as math. The bell rings, indicating it is time to move on to the next class and subject. By the time the student returns to math, perhaps after missing class the next day because of an assembly, the concept of the math problem is lost and so is the student. Far better would be completing the math problem without regard for ringing bells. The point is that in most traditional schools, the organizational structure is not set up to encourage transfer of subject matter from one class to another. Teachers have little time to cross subject lines with other teachers in order to integrate information.

2. *Procedural practices.* Procedural practices are those practices and policies set up to ensure that the school runs smoothly and to protect the safety of students and staff. Rules and discipline fall under procedural practices. The problem with rules, with the exception of rules that protect the safety of others, is that they sometimes become more important than educating the student. It makes little sense to suspend a student who is skipping school or to give a failing grade to a student who, for some understandable reason, is having difficulty with a subject. The disciplinary action does little to solve the problem. Such rules do not help the at-risk student and may convey the message that no one really cares if he or she does succeed. There should be consequences for not following school rules, but rules should not be designed to impinge on educating the student. At-risk students are the ones who suffer most from inflexible, unrealistic discipline policies regarding attendance, tardiness, and dress codes.
3. *Instructional strategies.* Limited or inflexible instructional strategies and poor pedagogy harm even the most gifted students. Students have different learning styles. A curriculum that is designed to fit a single teaching style rather than diverse student learning styles can be detrimental, especially for the at-risk student. A curriculum based on seat time rather than competence can also be a barrier for students who work at a slower pace and need more time. Further, a curriculum that is meaningless and disconnected from the student's out-of-school life can result in boredom and disengagement from school. Some of the brightest students have dropped out of school due to boredom and lack of challenge.

In addition to affecting within-school factors, the systemic approach challenges schools to consider the community as an asset instead of a problem, and to reach out to parents, businesses, and other community stakeholders. The goal is to forge partnerships with parents and the larger community because they also have a vested interest in seeing that students are successful in school. These partnerships often take the form of parent involvement programs, school-business compacts, and restructured schools that give parents more voice in everyday school decisions about discipline, scheduling, curriculum and instruction, and other areas that directly affect students.

Important here is to see the parents and community as having *strengths* that the school can build on. In distressed neighborhoods, communities are usually seen as possessing deficits rather than strengths. Parents of at-risk students are more often seen as part of the problem rather than part of the solution. Yet even in neighborhoods and homes with severe problems, there are strengths to build on, such as parents who want their children to succeed; businesses that are willing and eager to help by providing tutors, mentors, and real-world learning opportunities; and other agencies that are equally concerned about the welfare of students but who may have limited access or feel little connection to the schools. Note that the area of connection is of particular importance to counselors. It is school counselors who are usually in the best position to make the connections to community service and counseling agencies because counselors speak the same language and best understand what auxiliary services students may need from outside the school.

Some schools have experimented with becoming integrated service centers in which the school building becomes the place where all services are under one roof and thus easily accessible. In these centers, students not only receive their education but also have direct access to counseling and family services. The centers try to cut through the turf issues and red tape that often result when schools try to work with outside service agencies.

Several prominent school restructuring models for at-risk students stress the idea of greater partnership between the school and the community it serves. One is James Comer's School Development Program (Comer, 1980, 1988). The model focuses on responding to the child development and relationship needs of poor and minority students that are usually not well addressed by schools but when unaddressed impede academic progress. The model stresses applying child development principles to school decisions, which are made collaboratively by staff and parents who work together under a participatory management structure. The school is governed by a school planning and management team consisting of staff and parents. A unique feature of this model is that the school management works closely with a mental health team consisting of the social worker, counselor, special education teacher, and psychologist. In this structure, the mental health and child development experts are involved in important school matters rather than being isolated from the decision-making process. Decisions are based not only on students' academic needs but also on their child development needs. Another important facet of the model is that it creates less dissonance between the school and the home because it increases parent involvement in the school. Parents become partners with the school staff in seeing that the child development and learning goals are achieved. This is a promising model for at-risk students because it illustrates how teachers, administrators, mental health staff, and parents can work together in a partnership. Rather than one group blaming another, everyone becomes responsible for seeing that students succeed in school.

Another model for at-risk students that is being implemented in many elementary and middle schools throughout the country is Henry Levin's Accelerated Schools (Levin, 1987). At the heart of Levin's model is the notion of building on strengths discussed earlier. Students at risk are viewed as having strengths, including their own experiences, culture, language, and learning styles, that a school can build on in designing its curricular and instructional program. The model stresses greater parent involvement, empowering school staff and parents in school decision making, and the school's responsibility for accelerating the learning of all students. The idea is to think of the school community in broader terms than just staff and to involve parents and other community members in meaningful ways.

The main advantage of the systemic approach is that the school and community ultimately become responsible for the educational and related needs of students. Students are treated on an equal basis, with high but realistic expectations and goals being the norm for all students. The school system works cooperatively with social service agencies without, however, becoming a social agency. Schools also view parents as part of the solution rather than the problem, and look for the strengths that parents and community can contribute. Schools try to adapt to the needs of students rather than to the needs and convenience of the school bureaucracy. Our society has thrust upon schools the difficult but not impossible challenge of becoming more flexible for a diverse population without lowering educational standards. The challenge is to apply the research on at-risk students toward restructuring the system to better meet their needs. What is not often recognized is that this approach not only works to the advantage of the potential dropout but also is good education for all students.

## INTERVENTION STRATEGIES

The approaches discussed in the preceding section tend to be broad strategies for the prevention of school dropout. Because school dropout is a process and not a single event, and because it relates to many risk factors throughout a student's life and school career, it is difficult to distinguish between prevention and intervention strategies. Intervention strategies may be viewed as more closely targeted—although related to the broad prevention strategies discussed earlier. Together they define a comprehensive approach to the wide array of school dropout issues. Interventions, like prevention, can be divided into clinical approaches (student and family issues) and systemic approaches (school and community issues).

## Clinical Approach: Treating the Student and Family

A lack of family involvement can play a significant role in dropout behavior. As in the case study of Shamica, if the family structure is not stable, the school and social agencies must intervene by providing students with the support they need to succeed in school. It cannot be assumed that each student comes to school with a strong family support system. At Garfield High School in Los Angeles, Jaime Escalante (the math teacher who became famous for raising the math scores at a primarily Hispanic high school as depicted in the film, *Stand and Deliver*) reached out to parents to form parent support groups after finding out that many students did not have the resources in their own homes to study. Parents volunteered their homes for students to form study groups. In addition, many parents encouraged other parents to attend parent conferences at the school.

Even with families supportive of students, the school system needs to establish a positive rapport. Parents should be made to feel that the school is a partner in education, rather than an authority figure, and should be are encouraged to talk about their children. This is important because the school staff cannot understand the child's behavior until they know more about the family dynamics. Most families want their children to succeed. However, in many instances families are intimidated by school personnel and feel that their opinions even about their own children are not valued. Students who see that their parents are valued feel valued themselves. Whatever the situation, the school's greeting should be friendly and relaxed. It is difficult for a family to discuss a problem with those who look or act as if they wish the family member were not there. If families are in need of social services, they should be advised of these services, but in a way that avoids embarrassment. Helping staff learn to work with parents is important in helping students stay in school.

If at-risk students are to succeed, they need supportive family structures. Families can help their children by reading to them, by taking an interest in their school work and homework, and by asking questions and encouraging their children to make decisions. Families should try hard to provide a stimulating environment for their children by playing games, engaging in family activities, having positive discussions about school and their child's social life during meals, and encouraging responsible movie and television viewing. Families need to provide an environment in which their child feels safe, loved, and nurtured. For some parents, counselors may be able to assist by finding parenting workshops and other community resources.

The case study of Shamica showed a student with a tendency for being boisterous and acting out in school, which caused her to be suspended on several occasions. In addition, she was a young woman who was overweight and recognized that she was not making good choices in selecting healthy foods. Intervention strategies that might work for Shamica come in many different forms. The first and most important intervention is recognizing the underlying causes of difficult or dysfunctional student behaviors. School staff need to connect with students who do not have strong family structures as soon as possible and help develop some type of support system. The support system may be a close peer relationship with another student, a counselor, or other staff member who takes special interest in that student. Counselors and other staff should do everything possible to show positive feelings toward students experiencing difficulties. They should make praise and compliments both specific and sincere, such as, "You look proud of the way you finished that project. I know that you must feel good about the outcome!" Students should be made to know that their behavior has a positive effect on others. Students should be listened to as much as possible without judging. Their feelings should be acknowledged without always offering advice. As much as possible, school counselors should do something special for the discouraged student by taking time to talk to them one on one.

An important point about intervening with the individual student is that students should be empowered and not enabled. The worst possible insult to an at-risk student is to enable that student. Empowerment teaches students responsibility and makes them feel that they are in control of their lives rather than having others in control. Regardless of the students' gender, race, or culture, high expectations should be maintained at all times. Students realize immediately if expectations are low but will rise to the level of expectation of teachers and the school. Students who are exhibiting at-risk behaviors should be encouraged to participate in positive extracurricular activities. As noted earlier, research has indicated that students who participate in extracurricular activities respond more positively to school and may be more motivated to achieve academically.

One of the most important persons in all of this is the school counselor. The counselor is someone that a student should be able to count on. Counselors should, as much as possible, invite students to come to the counseling office during nonclass time—to get to know the student on a personal level and to reward them for success regardless of how small it is. A welcomed gift could be a student survival kit, containing, for example, a help card with the counselor's name/phone number and names/phone numbers of helping agencies, a positive mental thought attached to a bookmark, pamphlets on teen concerns, and anything else to help students feel that the counselor is someone they can count on. Counselors can also help organize school activities, such as a wellness week to help students understand good eating habits, guest speakers, fun runs, and Saturday walks. Student groups can also be organized using peer facilitators to assist students in discussing current youth issues and ways of promoting better study skills. The school counselor is one of the most resourceful persons with whom an at-risk student can connect.

## Systemic Approach: Changing the School and Community

In terms of specific interventions at the school level, the school should create a student-centered environment where curriculum is made relevant and stimulating to the student. Schools should stress relationships as much as restructuring by developing racial/cultural harmony and trust and caring between teachers and students. As in the case study of the inner-city school, when both students and staff feel alienated from each other and from school life, feelings of disengagement and hopelessness result for everyone in the building. Most teachers feel that their best experiences in school are when they connect with students personally and are able to help them in some way, although schools as currently structured allow teachers little time to do this. John Maguire (Center for Arts in the Basic Curriculum, 1993) of the Claremont Graduate School has stated that "When relationships are wrong between teachers and students, for whatever reason, we can restructure until the cows come home but transformation won't take place." When one high school student was asked what is the problem of schooling, his reply was, "This place hurts my spirit."

Beyond relationship issues, the curriculum and how it is delivered are the most important foundations for student success. This goes beyond teaching the basics of reading, math, and language to such other important areas as the arts. Arts that are taught as part of an integrated curriculum, as serious subjects with high standards, can produce students who are indeed engaged and excited about learning. Arts can provide some students with the opportunity to achieve academically at rates far beyond what they might be able to accomplish in subjects like math and science. This high achievement and high expectations can spill over into other disciplines. Arts education helps students appreciate and respect cultural differences and at the same time discern what they share in common with other people. Arts programs have been shown to enhance self-esteem and academic performance in a number of inner-city schools, such as the Saint Augustine school in the Bronx. Such programs can become a tool to tap and channel the creative energy of many at-risk students. An arts curriculum can address alternative learning styles and offer all children avenues for academic success. It can provide more reasons for students to want to stay in school.

No matter how excellent the school program, schools have little chance of helping at-risk students without the full support and involvement of the community. An African proverb states that "It takes a whole village to raise a child." A supportive and involved community is essential, especially in areas where many community risk factors can work against success in school. Most community organizations are anxious and willing to participate in school activities and assist in assuring that students are successful. Schools can embrace the community by proactively contacting local groups and working with them to address mutual concerns. Community groups, such as police and drug and alcohol rehabilitation counselors, are always willing to come and speak to student assemblies. Businesses and museums, in many instances, will sponsor prizes and discount coupons for students so that, especially in these times of budget constraints, students will be able to tour and do other activities that schools may no longer be able to afford. Community leaders are usually willing to come to speak during career days, and many companies will offer the time of their employees to serve as tutors or mentors. Health agencies are also willing to set up booths and help with sponsoring wellness events so that at-risk students understand the importance of good health habits. There are many community avenues for counselors and other school staff to pursue.

As noted in the section on prevention approaches, schools and communities must find creative ways to work together. It is in everyone's interest—schools, parents, businesses, local government, law enforcement agencies—for students to stay in school and succeed. Instead of seeing boundaries between the school and community, we must see opportunities for schools and communities to work together as a whole system to address the many risk factors that can lead to school dropout.

## ADAPTATIONS TO DIVERSITY

Throughout this chapter, we have emphasized that school dropouts come from many diverse backgrounds and circumstances, and that it is the school's responsibility to respond to student diversity so that *all* students succeed. Two specific diversity issues are important to understanding and preventing school dropout.

The first issue is family diversity. The demographics of the current American family play a large part in prevention and intervention strategies for at-risk students. Hodgkinson and Hamilton-Outtz (1992), and Hamilton-Outtz (1993), in their demographic profiles of American families, stated that most Americans still live in some type of family arrangement, but the traditional definition no longer applies. There are more married couple families *without* children than married couple families with children; more families with stepchildren; many more single-parent families with children; more fathers raising their children alone; and many more mothers in the labor force. What this indicates is that there are many families who are struggling and facing more challenging life styles. Schools, therefore, have a greater responsibility to provide for diverse family backgrounds. School counselors and other school staff should be prepared to deal with students who may have only one parent living with them, who have less adult supervision before and after school, and whose family situations are less stable than in the past.

The ethnic and cultural mix of today's students and how schools respond to these changing demographics is the second major diversity issue. It is one that we have already touched upon throughout this chapter. School systems, particularly those in urban areas and some states, are dealing with increasingly diverse student bodies. The demographic trends indicate that the bulk of the population growth in the United States in the last decade was primarily due to the increased number of minorities, many of whom are immigrants from poor, third-world countries. The states that increased in size in 1990 also increased in racial and ethnic diversity, and in states like Texas and California, minorities are becoming the majority. These minority groups include Hispanics, African Americans, Asians, Pacific Islanders, American Indians, and Alaskan natives. Hodgkinson and Hamilton-Outtz (1992) pointed out that one fallacy of the current debate on educational standards is the belief that all states begin at the same starting line in the race for educational excellence. The demographic trends suggest instead that some states more than others are dealing with poor, minority immigrant families who pose greater challenges for educational systems.

As discussed earlier, minority status is correlated with poverty, and the data show quite clearly that poverty status is linked to many risk factors that predict school dropout. We cannot talk about ethnic diversity without recognizing that many minorities represent poor families who have not been part of the American mainstream. Thus ethnic diversity raises two challenges for schools: Dealing with students from different social backgrounds and from different cultural and language backgrounds. This diversity means that students not only come to school with different primary languages and cultural values and learning styles, but also with vastly different life experiences and economic opportunities.

Poverty and its constellation of risk factors are major issues in many states and communities. Among the more prominent poverty-related risk factors are increased teen pregnancy, less access to health care, and increased violence and criminal behavior in poor communities. In high-poverty areas, education regarding birth control, increasing access to health care, and programs to prevent school and community violence will be necessary parts of a comprehensive dropout prevention strategy.

An important issue that relates to the cultural and social diversity of today's students is educational inequity. Educational inequity often comes in the form of lowered expectations that emanate from deeply held beliefs about the ability of different groups to succeed. Expectations that are lowered because a student is from a particular ethnic background or because the student is poor are unjust. Some teachers treat poor students differently from middle-class students, believing that poor students are not as capable as those from more affluent families. The same holds true for African American, Hispanic, and Native American students. Students who are made to feel that they are not valued are more likely to drop out. Ironically, these students may not have suffered from low self-esteem until they were put into a situation where little was expected of them. It is only when a student begins to question his or her self-worth that insecurities and low self-esteem are created. When students' social class and ethnicity are accepted by other students, teachers, and school counseling staff, they are much more likely to feel good about themselves and succeed. In the case of minority groups, this is more likely to happen if teachers and counselors are from the same ethnic background.

Aside from staff attitudes and expectations that are difficult to detect and change, a more obvious type of educational inequity is placing at-risk students in programs that fail to equip them with a full education. Some alternative programs may do an excellent job of building a comfortable shelter for the damaged student but may put the student in jeopardy if academic goals and expectations are drastically lower than those for students in the traditional school. At-risk students may later feel they have been cheated by alternative education because they are still unequipped to work and survive in mainstream society.

The school system that is committed to helping at-risk students and educating its entire population will attempt to restructure itself in order to meet the needs of all students. The role that counselors play in this reformation stage is crucial because counselors may know the multiple needs of students better than anyone else in the building. Counselors need to act as visionary guides who instill hope for the future in students, and as student advocates within the school system.

## SUMMARY

The placement of this chapter at the end of the book is fitting. The problem of school dropout involves many of the personal, family, and social issues discussed in previous chapters, and it is a serious problem that eventually harms both the personal lives of young people and our society. Counselors must help students realize that the easy choice to leave school is not necessarily the best choice in the long run. Young people who do not complete their high school education often feel deep regret later in life. As our society and economy change, dropouts will find it increasingly difficult to lead productive and satisfying lives. There is neither a single type of dropout nor a single magic pill that will help all of those who are at risk of leaving school. In addressing this multifaceted problem, counselors must assess many aspects of student functioning, including what is going on outside of school life, to develop effective interventions that address the whole student.

School counselors are an important link to families and community agencies whose help may be needed to deal with the whole student. Likewise, community counselors need to coordinate their services with schools. In addition, schools need to be more sensitive to the needs of students through more responsive structuring, scheduling, programs, and policies. Counselors can be effective advocates for at-risk youth in school committees and other forums to ensure that schools recognize and respond to the needs of a diverse student clientele.

The role of the counselor in helping potential dropouts should be, first, to give sound guidance to students who are already experiencing problems and establish primary prevention programs for all students. Second, counselors should play the role of communicator among students and school staff, parents, and community agencies, working to build a climate of caring and respect. For students who are disengaged from school or feel that they are being treated unfairly, caring and respect are needed before any counseling intervention can take effect. Third, the counselor should be an advocate and friend to students who may feel lost or shuffled from teacher to teacher in large schools. Teachers may feel responsible only for part of the student—that is, for student learning in a specific subject area. Counselors are in a better position to deal with the whole student and provide continuity throughout the student's school career, especially in large schools that are often very chaotic places.

Most high school counselors will agree that supportive guidance and counseling can help at-risk students have a more positive and productive school experience, especially those students who lack support in their home setting. Counselors are often responsible for helping students make decisions about their educational direction. In most cases, a counselor's daily routine is more involved with scheduling and dealing with behavior problems than with working as a team with teachers and other staff to develop holistic solutions. Student problems are too often addressed piecemeal in schools.

Districts that buy into the systemic approach realize that counseling is a valuable component of the total educational system. In addition to providing guidance and day-to-day assistance with discipline, counselors should be full partners in developing and implementing programs designed to foster child development and increase student academic and personal success. Administrators must define a larger role for counselors. Along with this larger role, counselors must receive adequate training in program development and in organizational and advocacy skills. Districts must support this expanded role by establishing lower student-counselor ratios so that counselors have the time to be involved in school-based and district-based decisions. Districts should consider more counseling services in the elementary grades so that early problems can be identified and dealt with more effectively.

In the movement to reshape education, much research has been done to describe and understand the dropout problem, but little has been said in the discussion about the importance of school guidance and counseling. School and community counselors are too often underutilized resources in helping at-risk youth. Counselors can be major contributors to the success of students who experience problems in school. As the movement to improve schools continues, an expanded role for school and community counselors needs to be considered.

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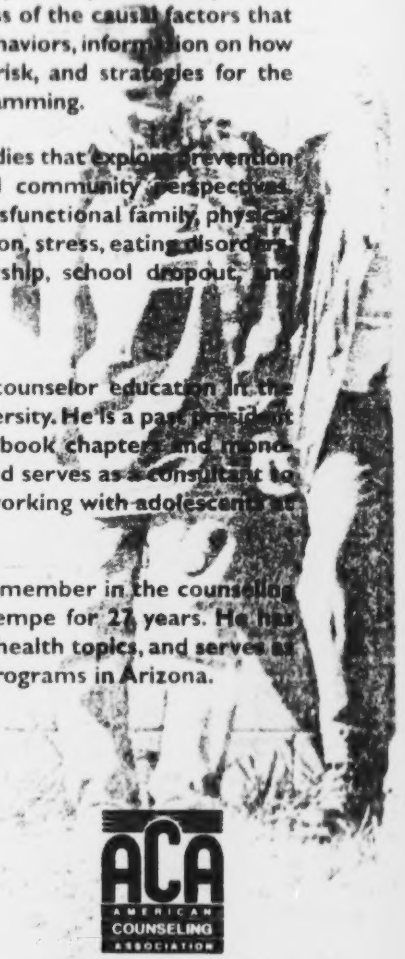
The number of children and adolescents who engage in behaviors that place them at risk for adverse consequences is increasing at alarming rates. In the second edition of this best-selling text, emphasis is placed on the importance of early prevention efforts intended to decrease the development of these destructive behaviors. The complexities of working with vulnerable youth are addressed by 24 experts who provide professionals and parents with an awareness of the causal factors that contribute to the development of at-risk behaviors, information on how to identify behaviors that place youth at risk, and strategies for the implementation of holistic, long-term programming.



This edition contains directives and case studies that explore prevention efforts from individual, family, school, and community perspectives. Topics discussed include, the effects of a dysfunctional family, physical and sexual abuse, low self-esteem, depression, stress, eating disorders, pregnancy, AIDS, suicide, gang membership, school dropout, and homelessness.

**David Capuzzi, PhD**, is a professor of counselor education in the School of Education at Portland State University. He is a past president of ACA. He has authored numerous textbook chapters and monographs on a variety of counseling topics, and serves as a consultant to school districts and community agencies working with adolescents at risk for suicide.

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